



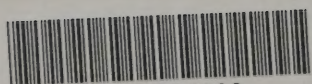
House of Commons
Health Committee

Health Inequalities

Written evidence

Session 2007–08

Volume II



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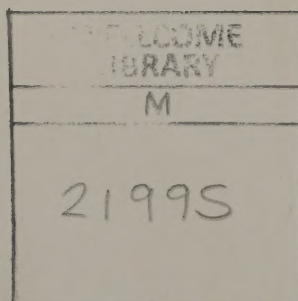
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Memorandum by the Department of Health (HI 01)

THE CONTRIBUTION OF THE NHS TO REDUCING HEALTH INEQUALITIES

The Health Select Committee announced, on 27 November, an inquiry into health inequalities. The inquiry will examine the extent to which the NHS can help achieve a reduction in health inequalities, particularly through primary care and public health services. The Department's response to the issues identified by the Committee is set out below.

THE CONTRIBUTION OF THE NHS TO REDUCING HEALTH INEQUALITIES

[ISSUE: the extent to which the NHS can contribute to reducing health inequalities, given many of the causes of inequalities relate to other policy areas e.g. taxation, employment, housing, education and local government]

KEY MESSAGE: reducing health inequalities requires a balanced approach between action in the NHS and action on the social determinants of health

1. Inequalities in health status and outcomes are determined by how and where people make a start in life and their early life experience, their education and occupational status, exposure to lifestyle and the environmental risks and diseases their life course predisposes them to.
2. The NHS affects peoples before birth to the end of life and helps to reduce risks throughout peoples sometimes too short a life journey. The NHS champions action to reduce health inequalities across government, regions, and communities, acting to help change peoples life course or mitigate the impacts of risks along the way, providing leadership and advocating for change.
3. People who live in the most deprived and challenging communities tend to experience the greatest health inequalities but health inequalities exist across all communities. NHS reforms have developed systems and processes to help reach people in the most disadvantaged groups and areas.
4. The setting of health inequality targets for the NHS established for the first time a set of national challenging improvements that the NHS, in partnership with other public services, must strive to achieve. The targets are to reduce health inequalities by 10% by 2010 as measured by infant mortality and to reduce health inequalities by 10% by 2010 as measured by life expectancy at birth.
5. Life expectancy has never been higher. Across all socioeconomic groups, life expectancy has increased year on year, and the NHS has played a significant role in this achievement. Cancer and cardiovascular disease rates are improving and the investment in health services has reached record levels. Similarly, infant mortality rates for all socioeconomic groups are at a historic low level but the rate of improvement has been greater in higher socioeconomic groups than for other groups.
6. The focus of government policy in the last decade has been to establish measures that still deliver overall improvements in life expectancy—but also reduce the relative inequalities across areas.

The Acheson inquiry

7. Health inequalities are the result of inequalities in living and working conditions, food supply and access to essential goods and services such as education and health care. *The Independent Inquiry into Inequalities in Health* (1998) concluded that tackling these inequalities requires action on a broad front if it is to be effective. Hence, the inquiry report highlighted the issues around poverty and income, education, employment and environment as well as the specific actions and the role of the NHS. This approach reflected the scientific evidence that emphasised the interrelated nature of the causes of these inequalities. It said that action that focuses solely on one aspect of policy is likely to be less effective than action linked to relevant factors in other policy areas.
8. Government policy on tackling health inequalities has reflected this balanced approach over the last 10 years. The Department of Health (DH) and the NHS have played key roles, catalysing and promoting actions through the engagement of partners across government and wider society which are focused on improving the health of those experiencing the greatest inequality of outcome.

The NHS Plan and the national targets

9. The NHS Plan (2000) highlighted the role of the NHS as a service committed to prevent as well as treat ill health.
10. It announced the first-ever national health inequalities targets for England providing a catalyst for national action in tackling health inequalities. The current version of the target reaffirmed in the new CSR is:
 - to reduce inequalities in health outcomes by 10% by 2010 as measured by infant mortality and life expectancy at birth

The national strategy

11. The Treasury-led cross-cutting review on health inequalities stressed the need for a strong focus on NHS action if the 2010 targets on infant mortality and life expectancy at birth were to be achieved. (*Tackling Health Inequalities: Summary of 2002 Cross Cutting Review*, 2002) This message was central to the Programme for Action, the cross-government national health inequalities strategy (*Tackling Health Inequalities: A Programme for Action*, 2003) published in 2003. This contribution focused on preventing illness and providing effective treatment and care, including through reducing risk through effective prevention, through early detection, intervention and treatment and improving access to effective care.

12. The national strategy has two aims to:

- help meet the 2010 national target and
- achieve a long-term sustainable reduction in health inequalities.

While the balance of action needed to achieve these aims is different, action in the NHS is crucial to the 2010 target with health inequalities at the heart of NHS service planning and performance, as reflected in the decision to make it a top priority in the NHS Operating Frameworks for 2006–07, 2007–08 and 2008–09.

Delivering the target

13. The challenging nature of the target prompted reviews of both the infant mortality and life expectancy aspects of the target across 2005 to 2007. These reviews focused on the role of the NHS and local government in delivering the target by reviewing the evidence, modelling the contribution of different factors to closing the health inequalities gap and exploring the realities on the ground. The reviews identified a clear understanding of the target and of what works as guiding the decisions of the NHS and other service commissioners. The reviews also increased the knowledge and confidence in improving delivery through local action.

14. For the life expectancy element of the target, this has meant focusing on high impact interventions, particularly among the over 50s, on reducing smoking among manual groups and on the prevention, effective management and treatment of other cardiovascular risk factors through primary care, particularly control of cholesterol and blood pressure. These interventions if systematically applied would help deliver the 2010 target. This enhanced analysis of delivery at a local level has also raised the commissioners understanding of what needs to be delivered. Currently 41% of local authority areas are on track to deliver against the target either for males, or females, or both.

15. The infant mortality review identified the key, mainly NHS, interventions most likely to contribute to the target. These include preventing teenage pregnancy, reducing smoking, maternal obesity and the incidence of sudden and unexpected deaths in infancy. It also highlighted the role of early antenatal booking in providing access to NHS support and services groups (*Review of the Health Inequalities Infant Mortality PSA Target*, 2007). Subsequently, the impact of the wider social determinants on the target has been recognised and modelled through child poverty, and housing and overcrowding. (*Implementation Plan for Health Inequalities Infant Mortality Target: A Good Practice Guide*, forthcoming 2007).

16. Most recently, the health and local government white papers *Our health, our care, our say*, and *Strong and Prosperous Communities*, further emphasise the drive towards reducing educational inequalities through more local services, built around the needs of individuals and communities, empowering local people, especially those with greatest need to lead healthier lives. Leadership across health and local authorities was strengthened through the appointment of the new post of Director of Adult Social Services and through joint appointments across health and local authorities of Directors of Public Health.

Our health, our care, our say committed the NHS to

- Put people more in control of their own health and care
- Enable and support health, independence and wellbeing
- Develop rapid and convenient access to high-quality, cost effective care

17. The DH *Commissioning Framework for Health and Wellbeing* (2007) put people at the centre of commissioning, promoting the use of information across boundaries to enable a better understanding of the needs of individuals and communities, including proposing the new Duty of Joint Strategic Needs Assessment which underpins the assessment of need at a local level.

18. The new NHS Next Stage Review, *our NHS, our future*, led by Lord Darzi is based upon the principles and vision of an NHS that is:

- Fair—equally available to all, taking full account of personal circumstances and diversity
- Personalised—tailored to the needs and wants of each individual, especially the most vulnerable and those in greatest need, providing access to services at a time and place of their choice
- Effective—focused on delivering outcomes for patients that are amongst the best in the world
- Safe—as safe as it possibly can be, giving patients and the public the confidence they need in the care they receive

19. The National Support Team (NST) on health inequalities was established in 2006 to work with local authorities and PCTs in the spearhead areas—the 70 local authority areas with the worst health and deprivation indicators. The NST explore the local context and systems and promotes the success factors for delivery and shares good practice on both aspects of the target. The Health Inequalities Intervention Tool was developed to support commissioners by identifying the interventions most likely to contribute to meeting the target in their area. It also encourages partnership work with local authorities to promote the wider, social and environmental improvements on health inequalities.

20. The incentives for NHS and Local Authorities partnership working have been aligned. A new line on All Age All Cause Mortality (AAACM), as a proxy for life expectancy, is now mandatory for Spearhead PCT Local Delivery Plans (LDPs) for 2007–08, and Local Authority Local Area Agreements (LAAs) from 2007. The same AAACM local trajectories to deliver the target have been agreed in current LAAs and LDPs. The AAACM indicator will also be in PCT plans from 2008–09 and is included in the National Indicator set for local government from which LAs choose indicators reflecting local priorities.

Role of resource allocation

21. The DH resource allocation seeks to ensure there is sufficient funding to provide equal access for equal need in all parts of the country, and to reduce avoidable health inequalities. Allocations are made to PCTs on the basis of the relative needs of their populations through a weighted capitation formula. This formula is weighted to include each PCT's "crude" population according to their relative need (age, and additional need) for healthcare and the unavoidable geographical differences in the cost of providing healthcare (market forces factor).

22. The development of the weighted capitation formula is continuously overseen by the independent Advisory Committee on Resource Allocation (ACRA). ACRA makes recommendations to Ministers on possible changes to the formula, prior to each round of PCT revenue allocations.

Review of Health Inequalities

23. In September 2007, the Secretary of State announced, in the interim Darzi review, his intention to develop a comprehensive strategy for reducing health inequalities which challenged the NHS, as a key player, to live up to its founding and enduring values of universality and fairness by:

- closing unjustified gaps in health status between individuals, whatever their background
- ensuring fair access to NHS services for everyone and
- treating all patients fairly, with high quality and good outcomes of care for all

24. This health inequalities review sits alongside the Darzi review and will aim to ensure that the NHS and other public service partners build upon the existing health inequalities policies and Public Service Agreements, ensuring that those experiencing the poorest inequalities in health outcome remain the focus of concerted and focussed evidenced actions,

25. It will build on the work and learning on tackling health inequalities over the last 10 years and draw on the latest available national and international evidence. Its aim is to develop a strategy for reducing inequalities in health status, in access, and in the outcomes of care, taking account of the wider social determinants of health. It will also look beyond the present targets for 2010.

26. The review is due to complete its work in the spring of 2008

THE ROLE OF GP SERVICES

[ISSUE: the distribution and quality of GP services and their influence on health inequalities (including how the Quality and Outcomes Framework and Practice-based Commissioning might be used to improve the quality and distribution of GP services to reduce health inequalities)]

KEY MESSAGE—there is scope to improve GP and primary care services, action to narrow health inequalities, action is in hand

27. The *Our health our care our say* white paper recognised the importance of better access to general practice for disadvantaged groups and areas and acknowledged the persistent and particular problems in these areas with the worst health outcomes—many of which have been under-served in terms of GPs and primary care provision.

Access and Health Inequalities

28. There is a strong correlation between areas with fewest primary care clinicians and those with worse health outcomes and high levels of deprivation. The number of primary care professionals by area is a cross government headline indicator identified by the Programme for Action.

29. The interim Darzi review published in September outlined a package of new measures to improve access to ensure GP practices across the country meet the needs of their local communities and deliver further improvements for patients.

30. These improvements include investing £250 million to deliver at least 100 new GP practices in the most deprived areas—those with fewest GPs and nurses, poorest health outcomes and lowest patient satisfaction—and up to 150 GP-led health centres across the country to increase capacity and improve service responsiveness and quality.

31. A national review is also underway to identify the reasons behind lower levels of satisfaction in accessing GP services, reported by people from BME groups. A report including recommendations for action will be produced in early 2008.

QOF and Health Inequalities

32. The Quality and Outcome Framework (QOF) already addresses the need to reduce health inequalities. The recorded prevalence of a disease affects how much money a practice receives for the relevant QOF points. Therefore if recorded prevalence reflects local expected prevalence, practices serving a population with greater need get more money. PCTs are also able to develop local quality frameworks in agreement with their contractors in order to address health priorities for their local population.

33. Although there are limitations to the data, QOF achievement data shows that QOF scores for practices serving the most disadvantaged populations are catching up with those of practices serving the least disadvantaged populations. Recent research shows that QOF scores between affluent and deprived areas are small and of relatively little clinical significance.

34. Continuous improvement is an underpinning concept of the QOF. The Darzi review will also be looking at how to reshape incentives to provide a stronger focus on health outcomes; whether there should be an independent process for setting and reviewing outcome measures in the framework; and whether there should be greater flexibility for PCTs in setting outcomes that reflect local needs and priorities.

Practice Based Commissioning

35. Practice Based Commissioning (PBC) can contribute to reducing health inequalities. It gives clinicians who are placed at the heart of communities, the tools to plan and shape the nature and range of services available to their local practice population so that these are tailored in a way that improves health outcomes and better meets local needs. In some cases, practices may also become key providers of community-based services in response to those needs.

36. By harnessing practices' professional experience of delivering care, PBC has a key role to play in delivering improved health outcomes through services designed around the needs of local people. Clinical engagement is central to World Class Commissioning that aims to enhance systematically the effectiveness of PCTs and PBCs to commissioning high quality and personalised services that will reduce health inequalities and improve health outcomes and well-being for their local population.

37. World Class Commissioning focuses on commissioning for outcomes. PCTs will be expected to choose, in partnership with practices and local authorities, up to 15 indicators relating to health improvement: reducing inequalities, increasing public confidence and patient satisfaction. PBC will contribute to this prioritisation of local health outcomes and provide clinical input to transform care at a local level. This will help ensure that the greatest priority is placed on those whose needs are greatest.

THE EFFECTIVENESS OF PUBLIC HEALTH

[ISSUE: the effectiveness of public health services at reducing inequalities by targeting key causes such as smoking and obesity, including whether some public health interventions may lead to increases in health inequalities; and which interventions are most cost-effective]

KEY MESSAGE—public health is most effective when action for health improvement is matched by action to tackle health inequalities

38. Public health has a role to play in reducing health inequalities through a range of interventions as set out in the *Choosing Health* (2004) White Paper. *Choosing Health* seeks to raise people's aspirations and improve their lifestyles using tools such as social marketing. Personalising packages of support are key and new mechanism and tools have been developed, such as health trainers to provide personal support for people in disadvantaged groups and areas; health literacy programmes to improve capability and uptake of services; and, LifeCheck to pilot health needs.

39. *Delivering Choosing Health* (2005) identified health inequalities as a key priority for making healthier choices easier through public health programmes like smoking, obesity, nutrition and alcohol.

40. The revised health improvement performance targets arising from the 2004 CSR included a health inequalities dimension to the cancer, CVD and stroke targets to strengthen this focus.

Smoking

41. Smoking is a major cause of health inequalities. This Government has done more than any other to tackle the smoking epidemic in this country.

42. There has been a significant reduction in smoking prevalence across all adults. There is some way to go to hit the target for routine and manual groups of 26% prevalence in 2010. However, the figures are moving in the right direction.

43. Additional funding has been provided for stop smoking services in spearhead areas (£10 million across 2006–07 and 2007–08) with significant success. The Healthcare Commission reported in 2007 that “support is excellent and where it is needed most”.

44. There is also specific work to target these smokers:-

- Continued hard hitting media campaigns which have been shown to be effective among routine and manual groups. This work has been coupled with an enhanced focus on why people smoke and through the evidence will help achieve better targeting of campaigns and services;
- A national support team on tobacco control which will disseminate best practice across all spearhead areas (for the most deprived parts of the country) and provide intensive support to those PCTs who need it;
- Evidence shows that stop smoking services are effective in targeting smokers from deprived communities and that accessible service delivery options are now available in a wide variety of settings—recent studies show that on average Spearhead areas now have a higher quit rate than other areas
- Smoke free legislation will protect routine and manual groups better since they are more likely to work in places where smoking has previously been unrestricted.

Alcohol

45. Alcohol is the third most important risk factor for European ill-health and premature death. It causes nearly 1 in 10 of all ill-health and premature deaths in Europe (The World Health Organization’s Global Burden of Disease Study) and there are big differences in the health consequences of alcohol use between richer and poorer local communities across all regions of England.

46. Much alcohol related harm is preventable. The evidence shows that significant reductions in alcohol related accidents, injuries, ill health and hospital admissions can be achieved through GPs or other health professionals identifying harmful drinkers earlier and providing brief advice about their drinking. Brief advice is more effective as a tool in encouraging harmful drinkers to reduce their drinking to low risk levels than for smoking cessation.

47. If systematically implemented, simple alcohol advice would result in 250,000 men and 67,500 women in the UK, reducing their drinking levels from harmful to low risk levels each year. It is estimated that an investment of £24 million in implementing early identification and brief advice could return savings to the NHS of £40 million over four years.

48. In order to help PCTs to make appropriate investment in alcohol and optimise savings and health benefits, there will be a national review of the cost to the NHS of alcohol-related harm. We are also developing a framework to support commissioners in planning local investment

Obesity

49. Obesity contributes to health inequalities as it:

- appears highest in the lower socio-economic groups, in more deprived areas
- reduces the prospects of employment—particularly in obese women
- has a higher prevalence among Black African, Black Caribbean, and (particularly male) Bangladeshi children, than the general population; and,
- it is more common among people with learning disabilities.

50. The Government has made significant progress in tackling obesity, including tougher rules on advertising to children, front of pack labelling, major investment to improve school food and sport, and 86% of school children now do at least two hours of quality school sport exceeding the national target.

51. The A new long-term ambition on obesity has been announced, including a child obesity indicator within the new cross-departmental child health PSA. A comprehensive cross-government strategy on obesity is being developed, building on the evidence in the Foresight *Tackling Obesity: Future Choices* report. The strategy is expected to be published early in the new year.

Nutrition

52. Good nutrition is crucial to health at all ages but there is evidence of serious inequalities. We are seeking to tackle these inequalities by

- Breastfeeding and infant health—Breastfeeding offers long term emotional, physical and mental benefits to mother and child. PSA 12 to improve the health and wellbeing of children and young people, includes an indicator on the prevalence of breastfeeding at 6–8 weeks: the indicator is included in both the NHS Outcomes Framework and the local government indicator set.
- Healthy Start—reaches around half a million pregnant women and children under four in low income and disadvantaged families, offering vouchers to spend on milk, fresh fruit and vegetables, and infant formula. It also offers contact with and support from health professionals.
- 5 A DAY—the message and consumption of fruit and vegetables are increasing across all regions and all social groups but consumption is far higher in high income households. This work is supported by the School fruit and vegetable scheme and new nutritional standards for school lunches which were introduced in 2006 and for other school food from 2007.

53. Salt targets—high salt intake increases the risk of high blood pressure, heart disease and stroke. Voluntary reductions in levels of salt in food for 85 product categories were agreed with industry in 2003, to be reviewed in 2008. A mass media salt campaign has been delivered to raise and maintain awareness of salt health impacts and what consumers can do to reduce intake.

Oral Health

54. Most oral diseases are preventable and despite big improvements over the last 30 years, there are still unacceptable inequalities across the country. The probability of having obvious decay experience in primary teeth is about 50% higher in poorer areas of the country compared with the better off areas (2003 *National Child Dental Health Survey*).

55. The Oral Health Plan for England (*Choosing Better Oral Health*, 2005) specifically focuses on reducing inequalities through a common risk factor approach. The key elements of the Plan are improving oral hygiene and:

- Improving diet and reducing sugar intake
- Optimising exposure to fluoride
- Tobacco control and promoting sensible drinking
- Reducing dento-facial injuries
- Professional training and support

THE IMPACT OF SPECIFIC PROGRAMMES

[ISSUE: whether specific interventions designed to tackle health inequalities, such as *Sure Start* and *Health Action Zones*, have proved effective and cost-effective]

KEY MESSAGE—specific programmes raise the health inequalities profile, promote innovative work and act as a catalyst for further local action.

Health Action Zones

56. The health action zones (HAZ) programme ran between 1997 and 2004 to explore mechanisms for breaking through current organisational boundaries to tackle inequalities and deliver better services. They pushed health inequalities up the local agenda, including raising the profile of “hidden” issues and groups.

57. HAZs served as a catalyst for promoting subsequent area based initiatives and underlined the lesson that there is no single blueprint for addressing the complex causes of health inequalities at the local level and progress can be made by small steps and by learning from different attempts in specific contexts to promote change. The work of HAZs has now been incorporated into PCTs

Sure Start

58. Sure Start Children's Centres, building on Sure Start local programmes (SSLPs) offer integrated local provision of help, advice, childcare and early education for children under 5 and their families.

59. They are a key mechanism for improving the life chances for young children, reducing inequalities in outcomes between the most disadvantaged and the rest, and helping to bring an end to child poverty. Through integrated services they help to address the variety of needs of young children and their families. The Government is committed to establishing one centre in every community (3,500) by 2010.

60. The early reports on Sure Start recognised that it takes time to demonstrate impact in improved outcomes for children and families, although they did find evidence of some improvements in health outcomes compared to England average, including.

- greater reduction in emergency hospitalisations for 0–3 year olds for severe injury or respiratory infection
- more signs that families in SSLP areas may be accessing routine health care locally, and a
- greater rate of smoking cessation among pregnant women

61. There is also evidence of the effectiveness of SSLPs in working with disadvantaged families, for example by engaging families previously hidden from mainstream services through assertive maternity outreach (*Maternity Services in Sure Start Local Programmes*—Zarrina Kurtz and Jenny McLeish with Anita Arora and Mog Ball. (2005).

THE CO-ORDINATION OF LOCAL ACTION

[ISSUE: the success of NHS organisations at co-ordinating activities with other organisations, for example local authorities, education and housing providers, to tackle inequalities; and what incentives can be provided to ensure these organisations improve care]

KEY MESSAGE—the systems, processes and tools are in place to allow effective and co-ordinated local action

62. Effective local action requires a coordinated joined up approach, secured across public services operating within a knowledge rich and effectively led local health and wellbeing community. Recent reforms now mean that many more PCTs and Local Authorities are co-terminus helping joint working and delivery and are closely aligned to meet targets. Nearly all Directors of Public Health (DPH) are now jointly appointed across PCTs and local authorities assuring joint leadership and planning structures are in place.

63. DPH appointments and the delivery system is underpinned by the new duty of Joint Strategic Needs Assessment (JSNA). PCTs and local authorities will seek, identify and share the needs of people and communities, developing strategic commissioning plans that target resources at areas of greatest need. JSNA assesses whether services commissioned to meet needs have delivered what they were commissioned to provide. JSNA sits alongside the Duty to Consult, further empowering local citizens voice, especially those who find it hardest to advocate or are seldom heard, are encompassed in strategic planning processes. In April 2008, all PCTs and local authorities will have to undertake a joint strategic needs assessment (JSNA) to identify current and future needs of their local population as the basis for the effective commissioning of services.

64. Partnerships between the NHS and local authorities are crucial to effective local action, particularly in the spearhead group for the life expectancy element of the target and the 43 areas with the highest numbers of infant deaths in the target group of those in routine and manual occupations. There is a significant overlap between these two areas.

65. Local action is supported by development of key tools, including the Health Inequalities Intervention Tool, the health poverty index and local basket of indicators to assess and monitor developments and the Beacon council award scheme to encourage good practice.

The NHS/local authority partnership

66. NHS organisations recognise the crucial role local authorities can play in tackling health inequalities and the benefits from working in close partnership to lead the local health agenda through the local strategic partnership. In addition to joint appointments and planning closer on-the-ground working is securing better service outcomes. Herefordshire PCT and local authority have appointed a joint Chief executive. Peterborough PCT has merged with the local social services.

67. LAAs incentivise action across local partnerships to deliver change on the ground, particularly improved health for the most disadvantaged. Reducing health inequalities is central to LAAs; currently all LAAs include the indicator which, while not being mandatory, remains part of the new LAAs from next June.

68. Health improvement and inequalities indicators are included in the National Indicator Set. DH has commissioned a major programme from the Improvement and Development Agency for local government to develop the capacity of local government to work in partnership with the NHS.

69. Monitoring delivery against LAAs is at Strategic Health Authority (SHA) and Government Office (GO) level. A Memorandum of Understanding [between whom?] has set the foundations to better align planning and service objectives to drive further improvements in health inequalities.

70. DH has commissioned a major programme from the Improvement and Development Agency for local government to develop further the capacity of local government to work in partnership with the NHS.

Working with communities

71. The Communities and Local Government-funded Neighbourhood Renewal Fund (NRF) and New Deal for Communities (NDCs) programmes promote practical partnership through a series of locally led initiatives to tackle priorities, such as addressing poor health as well as education, crime, worklessness, housing and liveability issues.

72. The NRF provides flexible funding for England's most deprived local authorities enabling local partners to improve services, including those relating to health. There are close links with the spearhead areas—61 out of 70 of them also in receipt of NRF.

73. The NDC programme, launched in January 2001, provides for 39 of the poorest neighbourhoods with the resources and support to tackle their problems and regenerate their communities, including through working with other agencies, notably PCTs.

74. NDCs have achieved modest improvements in reducing the number of people smoking (down 3 percentage points from 40% to 37%) and the number of people who feel their health is not good (a 3 percentage points reduction from 23% to 20%) between 2001–02 and 2005–06.

Working with others

75. The third and private sectors have a role to play in tackling health inequalities through Good Corporate Citizen and other programmes. The third sector is also involved in running Sure Start Children's Centres.

76. Schools play a part, including through the National Healthy Schools Programme. Local programmes give priority to schools serving the most deprived communities and this focus is reinforced by the funding formula, which provides local programmes with additional funding based on free school meals entitlement.

NATIONAL COORDINATION FOR THE TARGET

[ISSUE: the effectiveness of the Department of Health in co-ordinating policy with other government departments, in order to meet its Public Service Agreement targets for reducing inequalities]

KEY MESSAGE—effective partnerships have been in place since 2002 and have been sustained by work around the 2010 target

77. 12 government departments subscribed to the national health inequalities strategy (the Programme for Action). It included 82 departmental commitments that would both meet departments' own priorities and contribute to reducing health inequalities. The forthcoming 2007 Status Report is expected to show that most of these commitments have been delivered. The strategy was built on the co-operation developed through the Treasury led cross-cutting review and the partnership is sustained by active collaboration in pursuit of the target, such as through recent target reviews. Action on health inequalities has been overseen by successive cabinet sub-committees.

Working with DCSF

78. An example is through DH work with DCSF on a wide range of policies and programmes, including PSA targets on under-18 conceptions, childhood obesity and child and adolescent mental health services (CAMHS). This partnership extends to other important activities to improve children's and young people's health such as the National Healthy Schools Programme, development of Sure Start Children's Centres, emotional health and psychological wellbeing, and Family Nurse Partnerships.

79. This joint working has been further strengthened since July 2007 when the Prime Minister made the two departments jointly responsible for promoting the health of all children and young people. A formal structure for joint working between the two departments has been established, the Child Health and Wellbeing Board, to deliver PSA 12 on the health and wellbeing of children and young people and related work. The Board is jointly chaired at director general level, reporting through a Permanent Secretary-level group into the Cabinet sub-Committee DA(FCY).

Working with the regions

80. The GOs also have a role facilitating action across departments at regional level. Regional public health groups(RPHG) through their links with SHAs can help ensure the NHS plays its part and that connections are made with those overseeing action on the wider social determinants of health. They also lead in health and social care negotiations on LAAs for GOs.

81. For example, in the North West, the RPHG has worked with the Audit Commission to develop the Commission's review of health inequalities in the North West, initially in Cumbria and Lancashire. The recommendations from the Greater Manchester review were adopted by the NHS and local authorities and significant progress, particularly on strategic partnership working, is being made in the light of the review.

82. In Yorkshire and Humberside region, all PCT chief executives have a personal objective to reduce health inequalities, supported by targeted actions plans up to 2010. It is recognised that PCT action alone will not be sufficient to reduce health inequalities up to and beyond 2010. A whole system approach is being developed to help local leaders embed actions to reduce health inequalities in Community Strategies and LAAs.

MEETING THE 2010 TARGET

[ISSUE: whether the Government is likely to meet its Public Service Agreement targets in respect of health inequalities]

KEY MESSAGE—the target is challenging, some progress has been made but it will be difficult to meet all of the target

83. Progress against the national strategy is set out in an annual Status Report on health inequalities. The report assesses progress against the target, against 12 cross governments headline indicators and the 82 government commitments included in the Programme for Action. The 2007 report is currently in preparation and is due out next year and will be forwarded to the committee when published.

84. The health inequalities targets are challenging—some progress has been made, but there is still a great deal to be done if we are to meet all aspects of the target. The latest ONS data on the national target for 2004–06 compared to 2003–05 show that :

- infant mortality rates are at their lowest-ever level and that there has been a further slight narrowing of infant mortality gap between the routine and manual groups and the population as a whole—from 19% in 2002–04 to 18% in 2003–05 and 17% in 2004–06. The gap, however, remains wider than at baseline (13% in 1997–99) If this recent pattern continues, there is a good chance that this part of the target will be met though further progress will be needed
- life expectancy is increasing for both men and women, including in the Spearhead areas. The gap for male life expectancy between the Spearhead areas and the England average has remained stable at 2% above baseline (for 2004–06, compared to 2003–05), but for females the gap has widened in 2004–06 to 11% wider than at baseline, compared to 8% wider in 2003–2005.

85. The record in individual Spearhead areas shows that 40% of Spearheads are on track to narrow their own gap with England by 10% by 2010 compared to baseline for either males, or females, or both. Targeted support to these areas is being provided through the National Support Team for health inequalities to provide strategic support and to identify promote good practice.

86. It was agreed to monitor progress against cross-government indicators to give a broader picture of developments across the wider social determinants—such as child poverty, housing and educational attainment—and other NHS indicators, including targets on improving the health of the population such as cancer, CHD and smoking in manual groups set in 2004.

87. The time lag between interventions and the achievement of results means that it is difficult to assess the short-term contribution of individual programmes towards the target. The Programme for Action observed that the impact of programmes is likely to be most visible towards the end of the decade.

88. A scientific reference group on health inequalities chaired by Professor Sir Michael Marmot of UCL and supported by leading academics and other experts oversees the development of the Status Report.

CONCLUSION

89. Health inequalities are persistent, stubborn and difficult to change. Reducing them requires a balanced approach on a broad front between the role of the NHS on prevention and treatment of disease and local government, working in particular on the contribution of the wider social determinants of health. We have ramped up significantly the contribution of the NHS to the target, most recently through the reviews of both aspects of the target. The lessons from the reviews and the focus it provides have shaped the most recent CSR. The new PSA framework will help strengthen a cross government approach to health and well being, including on health inequalities. The common indicator base developed through the Operating Framework for the NHS and the National Indicator Set for local government will provide a focus for local action.

90. These efforts are being complemented by actions of the wider social determinants. This will be key in achieving a long-term sustainable reduction in health inequalities that modifies health status and the life chances of people living in disadvantaged groups and areas. Action is already in hand to break the cycle of poverty and deprivation across the generations. This challenge is being taken up across government in a range of programmes—on education, housing, and poverty—as part of wider action on poverty, inequality and social justice.

January 2008

Memorandum by Imperial College of Science, Technology and Medicine (HI02)

THE IMPACT OF THE QUALITY AND OUTCOMES FRAMEWORK (QOF) ON INEQUALITIES IN CHRONIC DISEASE MANAGEMENT IN PRIMARY CARE

EXECUTIVE SUMMARY

1. The Quality and Outcomes Framework (QOF) introduced as part of the new general practitioner contract presents an important opportunity to reduce known inequalities in the management of chronic conditions. This submission provides a rapid appraisal of published research examining the impact of the QOF on inequalities in chronic disease management

2. Results from research studies which have used national contract data suggest that there were small differences in QOF performance between practices working in deprived and affluent areas in the first year of the contract. These differences appear to have narrowed in the second year of the contract. Studies using individual patient data suggest that there were marked age, gender and ethnic group inequalities in the quality of care being delivered before the introduction of QOF. Some of these inequalities have been partially attenuated afterwards.

BACKGROUND

3. In addition to improving overall health care quality, the Quality and Outcomes framework (QOF) introduced as part of the new general practitioner contract presents an important opportunity to reduce known inequalities in the management of chronic conditions through an ongoing emphasis on improving the quality of care being delivered to all patients. However, concerns about the potential negative impacts of pay for performance programmes such as QOF on health inequalities have also been raised.¹ For example, lower QOF performance, resulting in reduced funding to a general practice, may perpetuate the inverse care law whereby the poorest communities with the highest health needs receive the lowest provision of primary health care.

¹ Casalino, L.P. and A. Elster, Will pay-for-performance and quality reporting affect health care disparities? *Health Affairs*, 2007. 26(3): p. w405–14.

4. Research on QOF and inequalities can be divided into studies that have used:

- (1) national QOF data from QMAS and
- (2) existing primary care datasets containing patient level information.

STUDIES USING NATIONAL QOF DATA

5. National QOF data is only available on general practices, PCTs, SHAs, and for England (ie individual patient data is unavailable). Studies using national QOF data have generally found that practices situated in less deprived areas achieve higher QOF scores.^{2,3,4,5,6} However, the gaps between practices in prosperous and poor areas have tended to be fairly small and more recent analyses suggest that these differences may have diminished further in year 2 of the new contract.⁷

6. The scope for assessing the impact of QOF on known inequalities in chronic disease management using QMAS data is limited for several reasons. Firstly, the data lacks crucial patient level information on variables such as age, sex, ethnicity and deprivation. As such these studies are restricted to undertaking ecological analyses using practice assigned, area-based measures of socio-economic status. Secondly, the ability of practices to “exception report” patients means that the quality of care delivered in different areas and to different patient groups may be much more variable than this data indicate. At least one study has found that practices with more deprived patient populations are more likely to report “exceptions” for QOF indicators.⁸ Finally, no baseline data is available to assess the extent of inequalities before the introduction of QOF.

STUDIES USING DATASETS WITH PATIENT LEVEL INFORMATION

7. Findings from a smaller number of published studies which have used individual patient level information suggest that the impact of QOF on inequalities has been mixed. The findings suggest that while care was largely equitable between ethnic groups when assessed using process of care measures,^{9,10} inequities in prescribing and intermediate clinical outcomes between ethnic groups evident before the implementation of QOF have persisted after its implementation.¹¹

8. These studies examined trends in the quality of care for Coronary Heart Disease (CHD), hypertension and diabetes before (April 2003) and after (December 2005) the introduction of QOF in Wandsworth, south London. This work is part of a wider programme of research which has been evaluating the impact chronic disease management initiatives for cardiovascular disease and diabetes since 1998.

² Ashworth, M., Armstrong, D. (2006). The relationship between general practice characteristics and quality of care: a national survey of indicators used in the UK “Quality and Outcomes Framework”, 2004–5. *BMC Family Practice*, 7, 68.

<http://www.ingentaconnect.com/content/rcgp/bjgp/2007/39283057/00000539/art00005?token=004b1950f38ac52a12f653b2a2d3a7c4e7247704f7e41225f406a535747465476783b6f4455>

³ McLean G, Sutton M, Guthrie B. Deprivation and quality of primary care services: evidence for persistence of the inverse care law from the UK Quality and Outcomes Framework J Epidemiol Community Health. 2006 Nov;60(11):917–22. <http://jech.bmj.com/cgi/content/full/60/11/917>

⁴ C Millett, J Car, D Eldred, K Khunti, A Mainous, A Majeed. Diabetes prevalence, process of care and outcomes in relation to practice size, caseload and socio-economic status: national cross-sectional study in primary care. JRSM 2007;100: 275–283. <http://www.jrsm.org/cgi/content/full/100/6/275?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=millett&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT>

⁵ Saxena S, Car J, Eldred D, Soljak M, Majeed A. Practice size, caseload, deprivation and quality of care of patients with coronary heart disease, hypertension and stroke in primary care: national cross-sectional study. BMC Health Serv Res. 2007 Jun 27;7:96. <http://www.biomedcentral.com/1472-6963/7/96>

⁶ Doran, T., Fullwood, C., Gravelle, H., Reeves, D., Kontopantelis, E., Hiroeh, U., Roland, M. (2006). Pay-for-performance programs in family practices in the United Kingdom. *N Engl J Med*, 355, 375–384. <http://content.nejm.org/cgi/content/full/355/4/375>

⁷ Ashworth, M., Armstrong, D., Seed, P., Durbaba, S., Jones, R. The relationship between social deprivation and the quality of primary care: a national survey using indicators from the UK Quality and Outcomes Framework. *Br J Gen Pract* 2007;57, 441–448. <http://www.biomedcentral.com/1471-2296/7/68>

⁸ L. A. Sigfrid, C. Turner, D. Crook, S. Ray. Using the UK primary care Quality and Outcomes Framework to audit health care equity: preliminary data on diabetes management. *Journal of Public Health* 2006; Vol. 28, No. 3, pp. 221–225. <http://jpubhealth.oxfordjournals.org/cgi/content/full/28/3/221>

⁹ Gray, J., Millett, C., Saxena, S., Netuveli, G., Khunti, K., Majeed, A. Ethnicity and quality of diabetes care in a health system with universal coverage: population-based cross sectional survey in primary care. *J Gen Intern Med* 2007; 22, 1317–20. <http://www.springerlink.com/content/m734751641272703/>

¹⁰ Millett C, Gray J, Saxena S, Netuveli G, Majeed A. Impact of a pay for performance incentive on support for smoking cessation and on smoking prevalence among people with diabetes. *CMAJ* 2007; 176(12):1705–10. <http://www.cmaj.ca/cgi/content/full/176/12/1705>

¹¹ Millett C, Gray J, Saxena S, Netuveli G, Khunti K, Majeed A. Ethnic Disparities in Diabetes Management and Pay-for-Performance in the UK: The Wandsworth Prospective Diabetes Study. *PLoS Medicine* 2007; 4(6): e191. doi:10.1371/journal.pmed.0040191.

<http://medicine.plosjournals.org/perlserv/?request=get-document&doi=10.1371/journal.pmed.0040191>

Key findings from the Wandsworth research programme

CORONARY HEART DISEASE

9. The percentage of patients meeting national treatment targets increased between 2003 and 2005: for blood pressure (140/80 mm Hg) from 52% to 59% and for cholesterol (5 mmol/L) from 66% to 74%. Worse blood pressure control in black patients relative to whites that was seen in 2003 was less marked in 2005.

10. The programme found increases in prescribing of aspirin (82% to 88%), statins (69% to 80%), beta blockers (40% to 45%), and ACE inhibitors (58% to 65%) between 2003 and 2005. In 2005, black patients were less likely to be prescribed a statin than white or south Asian patients (75% v 80% v 84%) after taking into account the different age distributions of the different ethnic populations.

11. In 2005, patients aged 75 years and over with CHD were less likely to be prescribed a beta blocker, aspirin or an ace inhibitor.

Age	Beta blockers	Aspirin	Ace inhibitors
45-54	58% (n = 208)	90% (n = 208)	67% (n = 92)
55-64	48% (n = 630)	90% (n = 630)	66% (n = 221)
65-74	48% (n = 986)	90% (n = 986)	68% (n = 368)
75 +	39% (n = 1231)	85% (n = 1231)	61% (n = 479)

12. In 2005, women were less likely to be prescribed a beta blocker (39.8% v 48.7%), aspirin (82.1% v 88.5%) and an ace inhibitor (59.3% v 67.0%) than men. Women were less likely to meet the treatment target for cholesterol (65.2% v 79.0%).

DIABETES

13. The percentage of adult patients (\geq 18 years) meeting national treatment targets increased between 2003 and 2005: for blood glucose (7.0%) from 35% to 37%, blood pressure (140/80 mm Hg) from 31% to 42% and cholesterol (5.0 mmol/L) from 58% to 70%.

14. In 2005, south Asian and black patients with diabetes were less likely to meet the target for HbA1c than white patients (31% v 36% v 42%). Black patients with diabetes were less likely to meet the target for blood pressure than white or south Asian patients (37% v 46% v 45%).

15. Prescribing increased between 2003 and 2005: for oral hypoglycaemic agents from 53% to 67%; for insulin from 20% to 29%; and statins from 38% to 60%.

16. In 2005, black patients with diabetes were less likely to be prescribed a statin than white or south Asian patients (56% v 64% v 62%). South Asian patients were less likely to be prescribed insulin than white and black patients (22% v 33% v 30%).

17. In 2005, younger adult patients (18-44 years) with diabetes were less likely to meet treatment targets for cholesterol and HbA1c. In 2005, women were less likely to meet the target for cholesterol than men (64% v 77%).

18. In 2005, younger patients (18-44 years) were less likely to be prescribed oral hypoglycaemic agents, statins and antihypertensives but more likely to be prescribed insulin than older patients.

HYPERTENSION

19. Achievement of BHS targets for hypertension and prescribing of anti-hypertensive drugs has also been assessed. Black patients were significantly less likely to meet the BHS target for blood pressure control after controlling for age differences between ethnic groups. Prescribing of anti-hypertensives differed significantly between ethnic groups.

	BHS target*	Ace	Beta	Calcium	Diuretic
White British	47.7%	49.9%	26.6%	34.5%	43.2%
Black	41.5%	45.7%	21.9%	55.4%	47.7%
South Asian	51.9%	54.0%	26.1%	38.6%	34.6%

* \leq 140/85 mm Hg (140/80 mm Hg in people with diabetes)

CONCLUSIONS

20. Results from research studies which have used national contract data suggest that there were small differences in QOF performance between practices working in deprived and affluent areas in the first year of the contract. These differences appear to have narrowed in the second year of the contract. Studies using individual patient data suggest that there were marked age, gender and ethnic group inequalities in the quality of care being delivered before the introduction of QOF. Some of these inequalities have been partially attenuated afterwards.

Christopher Millett, Azeem Majeed

Department of Primary Care and Social Medicine, Imperial College

December 2007

Memorandum by Adam Oliver (HI 03)

HEALTH INEQUALITIES

The NHS is founded on, and at least according to government rhetoric, is still based upon, the principles of universality, comprehensiveness and affordability, principles that lend themselves to equal access for equal need. However, the Labour government has focussed its sights upon reducing inequalities in health outcomes, as emphasised in the NHS Plan, its blueprint for a ten year reform of the NHS, published in 2000. In the NHS Plan, the government committed itself to establishing national health outcomes inequalities targets to narrow the health gap between socio-economic groups and between different areas of the country. Specifically, these targets are:

- (i). By 2010 to reduce by at least 10% the gap in mortality between routine and manual groups and the population as a whole.
- (ii). By 2010 to reduce by at least 10% the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole.

The government has proposed a great many policy initiatives that it hopes will contribute towards achieving these targets, from the introduction of a national minimum wage, to improving lifelong learning opportunities in education, to rebuilding deprived local communities, but simply by being part of the NHS Plan, the government clearly perceives the NHS to play a large role in this area. But one can question on several levels the appropriateness of using the NHS as a direct means to redistribute health outcomes across socio-economic groups.

For instance, much of the NHS is concerned with what can loosely be termed “curative” health care, for people with chronic and acute conditions. Attempts at redistributing health outcomes in this context would require the systematic prioritisation of some ill people over others, on the basis of factors—such as income and/or social class—that are exogenous to their health. Such prioritisation would be discriminative, would undermine the notion of universality and would raise serious ethical concerns. For example, consider a situation where there are two ten year old boys, one the son of a plumber and the other the son of a lawyer, who are similar in all other respects. Imagine they are both in need of a kidney transplant operation, but that there is currently only one available kidney that, by coincidence is a match for them both. If the NHS was used to redistribute health outcomes across social groups, the plumber’s son would be systematically prioritised over the lawyer’s son as a matter of policy, because plumbers, on average, currently have a lower life expectancy (for example) than lawyers. Although this is admittedly a highly stylised example, it does illustrate that prioritising people over potentially life and death matters on the basis of their occupation (or their fathers’ occupations) would be, for many, morally problematic.

Quite apart from the ethical concerns, there are political considerations to take into account if one were to prioritise for and against particular social groups in a universal tax-financed system such as the NHS. That is that the NHS is founded on the notion of “from each according to his/her means, to each according to his/her need”; that is, the NHS relies for its funding on middle class support. If those on relatively higher incomes felt as though they were being systematically prioritised against relative to those on lower incomes, this would risk undermining their up until now high levels of support for the NHS. Potentially, more people would forsake the NHS for the private sector, and vote for political parties that favour dismantling the NHS at general elections. Ultimately, using the NHS as a means to redress health outcomes inequalities may leave the UK with a poorly publicly financed service for the poor.

Adam Oliver

LSE Health

December 2007

Memorandum by GlaxoSmithKline (HI 04)

THE CONTRIBUTION OF THE NHS TO REDUCING HEALTH INEQUALITIES

INTRODUCTION

1. GSK welcomes the Health Select Committee's Inquiry into the contribution of the NHS to reducing health inequalities. We welcome also the opportunity to provide input on this topic, particularly in light of our involvement in a range of areas within healthcare provision.

2. This submission focuses on GSK's experience principally as it relates to the prescription pharmaceuticals, vaccines and over-the-counter medicines which we research, develop and manufacture. However, due to our long-term involvement in UK healthcare, we will also address those areas within the terms of reference of which we have particular experience.

INTRODUCTION TO GLAXOSMITHKLINE

3. The pharmaceutical industry makes a significant contribution to the health and wealth of UK citizens by employing and developing highly skilled workforces, investment in research and development, healthy working populations, efficiencies in healthcare system, and exports to the rest of the world. In the UK alone, the pharmaceutical industry contributes over £3 billion a year to research and development and employs over 80,000 people in R&D, manufacturing and other related activities.

4. GSK is one of the world's leading research-based pharmaceutical and healthcare companies. The company's mission is to improve the quality of human life by enabling people to do more, feel better and live longer. We are involved in the research, development, manufacture and commercialisation of prescription pharmaceuticals, vaccines, over-the-counter medicines, and health-related consumer products.

5. In 2006, GSK invested £3.5 billion in R&D globally and the UK benefited from £1.3 billion of this, making us the single largest private sector funder of R&D in the UK. Globally, our R&D organisation employs almost 15,000 people, with nearly 6,000 of those employed in the UK, where we have nine R&D sites.

6. This submission is being made on behalf of GSK's UK Pharmaceuticals and Consumer Healthcare Divisions.

THE EXTENT TO WHICH THE NHS CAN CONTRIBUTE TO REDUCING HEALTH INEQUALITIES

7. The NHS was founded on the principle of fairness yet issues regarding equity around access to innovative medicines continue to attract considerable attention. Access to such medicines frequently depends on where a patient resides whilst the principal barrier to more uniform access appears to relate to poor financial planning within NHS Trusts and poor implementation of guidance issued by NICE. This has led to the perception that, whilst PCTs appear to be quick to enforce negative NICE decisions, positive ones are implemented slowly or not at all. The UK remains one of the slowest adopters of new medicines in Europe, meaning that patients are denied new medicines which could benefit their health and enhance the quality of their lives or that new medicines use is limited to the last line of care after other options have failed. This means that few patients have the opportunity to obtain the full benefit from the medicine because their disease has progressed to such an extent that the incremental benefit possible is limited because of the delay in the use of the medicine.

8. Improved implementation of NICE guidance could generate greater equity of access to new medicines and treatments. This could be driven through Healthcare Commission reviews, which could be extended to monitor and track levels of implementation within Primary Care Trusts. Existing mechanisms such as the Quality Outcomes Framework (QOF) could also be used to drive uptake of guidance. The Framework was introduced as part of the new General Medical Services contract in April 2004 and has been instrumental in changing prescribing behaviour. The implementation of NICE guidance could be incorporated into the QOF, which could then incentivise doctors to implement good practice prescribing based on this guidance.

EFFECTIVENESS OF PUBLIC HEALTH SERVICES AT REDUCING INEQUALITIES BY TARGETING KEY CAUSES

9. There are several areas in which GSK is active that also experience health inequalities. We outline these as below:

Smoking Cessation

10. An area in which the NHS can and is contributing to decreasing health inequalities is smoking cessation, an area in which GSK has significant experience. The Department of Health (DH) has a clear focus on reducing smoking prevalence, with 2010 targets of 21% in adults and 26% in Routine & Manual Workers. As smoking is the single biggest cause of health inequalities¹², achievement of these targets would make significant inroads to reduce health inequalities.

11. Differences in the prevalence of smoking between the higher and lower social classes accounts for over half the difference in the risk of premature death¹³. In addition to noting this, it is worth considering also the impact of smoking on babies, young children and others exposed either directly or indirectly to second-hand smoke as this also generates differences in health quality across the social classes.

12. As smokers in different socioeconomic groups experience different rates of success in quitting smoking, the potential exists for the Stop Smoking Services to lead to widening health inequality by targeting only those more likely to succeed, ie, those in higher socioeconomic groups. The targeting by the English Stop Smoking Services to achieve specific numbers of quitters in the 2003–2006 Planning period initially had the effect of disincentivising the development of strategies to attract smokers from priority groups, which also represented those groups less likely to prove successful¹⁴.

13. More recently, however, the Health Commission has reported a higher performance in Tobacco Control in Spearhead PCTs and those with higher deprivation indices¹⁵ but these programmes and targets need to be carefully developed in order to prevent unexpected, and unwelcome impacts on health inequality.

Immunisation

14. Immunisation is one of the best instruments to reduce health inequalities as, when provided to all citizens, it is an extremely effective, and non-discriminative, form of public health. Smallpox, for example, has been eradicated by immunisation and in most of the developed world, childhood death from disease is rare due to mass vaccination against a variety of diseases.

15. The success of the UK's vaccination programme is largely taken for granted, however, some children are not routinely vaccinated against diseases such as measles and whooping cough. Consequently, sporadic outbreaks of measles have occurred in the UK, sadly recently resulting in the first death in 14 years from related complications.

16. People's awareness of the importance of vaccination needs to be raised, particularly that of parents with young children. The value of vaccines should also be raised amongst other sectors of society, as populations become more dynamic, with emigration, immigration and inter-continental travel increasing the speed with which people in the UK are exposed to disease¹⁶.

17. The future potential of vaccines to continue to address health care inequalities is significant and GSK strongly welcomes the UK Government's commitment to introduce a vaccination programme in 2008 to protect women against the human papilloma virus (HPV), which is the main cause of cervical cancer. GSK has recently launched its vaccine, Cervarix, which protects against the two main strains of HPV. Through the provision of such vaccines, public health services can reduce health inequalities emerging, in this example by ensuring that all appropriate women in the UK should have access to vaccination against HPV.

Flu

18. Seasonal flu represents a particular danger to specific groups in the community, such as young children, older people, and those with serious heart conditions and other chronic illnesses. Typically, between 3000–4000 people will die from flu-related illness in the UK every year whilst, in the epidemic of 1989–90, there were almost 30,000 deaths.

19. To reduce health inequalities, more could be done to ensure that vulnerable sections of society are adequately protected against seasonal flu. Currently the NHS provides free vaccination for over 65's and people with certain long-term chronic conditions. The option of free seasonal flu vaccine should be extended to encompass an age range that includes middle aged workers who may be susceptible to flu related

¹² "Fact sheet on Tobacco", DH, October 2006.

¹³ Jarvis M, Wardle J (1999), Social patterning of individual health behaviours: the case of cigarette smoking. In Marmot M, Wilkinson R, editors *Social Determinants of Health*, Oxford: Oxford University Press.

¹⁴ "Targeting smokers in priority groups: the influence of government targets and policy statements", Pound E. *et al*, *Addiction*, 100 (Suppl. 2) pp28–35.

¹⁵ *No ifs, no buts: Improving services for tobacco control*, Healthcare Commission, January 2007.

¹⁶ "*Valuing Vaccines—an investment for our Future*", UK Vaccination and Industry Group Publication, 2007.

complications arising from early onset chronic disease. A proposal would be to lower the age limit to 50 to encompass this group to reduce the burden of illness, reduce associated complications and potentially improve productivity.

20. In addition, the risk of influenza infection exacerbating any underlying disease that a patient may have should be considered in addition to the risk of the influenza itself. The clinical needs of individuals with multiple sclerosis and related diseases or hereditary and degenerative diseases of the Central Nervous System are a specific example.

21. Similarly, in its planning for a potential avian flu pandemic, the government should ensure that a full range of measures are considered. GSK is working closely with the Government to ensure that the UK is as well prepared as possible. This includes developing a pre-pandemic vaccine which “primes” people’s immune systems and should give a degree of protection at the start of a pandemic; and a vaccine against the actual pandemic strain.

22. GSK is also manufacturing our antiviral, Relenza, which is in the same class of antivirals as Tamiflu and is currently the only alternative to it. As an inhaled medicine Relenza targets the lung, which is the site of flu virus replication, and has limited absorption into the rest of the body. The Royal Society advocates the UK Government building a stockpile comprising a mix of antivirals because of potential resistance to Tamiflu.

Respiratory Illness

23. Respiratory illness is another area where significant health inequalities exist in the UK and another where public health services can play a significant role. One person in seven in the UK is affected by a lung disease, such as asthma or COPD and every year around 68,000 people in England are admitted to hospital as a result of an asthma attack. It is estimated that three quarters of these admissions can be prevented as, although asthma is serious and widespread, most people can control it with the appropriate support.

24. However, standards of care differ enormously across the UK. This year, a report launched by Asthma UK, “The Asthma Divide”, showed that patients continue to suffer health inequalities with regards to their respiratory treatment. The report highlighted that hospital admissions for asthma are 65% higher in some regions of England than in others and that admissions can vary widely between even neighbouring PCTs.

25. The appropriate provision and use of medicines can help to bridge the inequalities in care that allow asthma to remain uncontrolled. By improving routine care in the public health service, the need for emergency hospital treatment could be decreased, reducing stress on patients and saving millions of pounds.

26. To address this inequality, the Government should commit to delivering minimum standards of care for all patients as set out by Asthma UK in their recent report. These include:

- Easy access to a healthcare professional with specific asthma training, timely and accurate diagnosis of asthma;
- Receiving regular and proactive asthma reviews; and
- Being offered a written personal asthma action plan

27. Inequalities in treatment are even more acute for patients suffering from chronic obstructive pulmonary disease (COPD.) This condition, an umbrella term for lung disease such as emphysema and chronic bronchitis, kills around 12,000 people annually in the UK. However, awareness remains very low, especially amongst women of whom it kills almost as many as breast cancer. In addition, COPD is the only major cause of death whose incidence is increasing.

28. Greater awareness of the condition amongst GPs and the appropriate use of innovative medicines would help more patients control their condition and reduce incidents of exacerbation which result in hospital admission. GSK strongly welcomes the Government’s announcement of the creation of a National Service Framework for COPD and anticipates that it should result in improved care for patients. The Government could go even further by ensuring implementation of NICE guidelines for use of medicines in COPD and the Healthcare Commission could monitor standards of care and management of COPD patients to ensure greater equality of standards.

Cancer

29. Considerable progress has been made on cancer over the past decade. Cancer mortality in the UK has fallen; survival rates for many cancers are improving as are patients’ experiences of many forms of treatment. The Government has also taken bold steps on smoking which should be commended, and is now focusing on other aspects of public health which are known to contribute to rates of cancer, such as obesity.

30. GSK welcomes the recent Cancer Reform Strategy, which will bring benefits to cancer patients across the UK, by further reducing mortality rates and addressing current inequalities in cancer care. Tackling cancer requires a coordinated approach across Government, and this strategy should bring the NHS into line with levels of service experienced in Europe.

31. However, more work needs to be done to ensure that appropriate patients are given access to new and innovative medicines as part of their treatment. GSK is committed to working with the Government to improve levels of access and uptake but believes that, in a cost-driven climate, there is a risk that evaluation mechanisms will run counter to what should be their key objective: identifying medicines that bring the greatest benefit to patients, ensuring early access to these medicines, allowing choice among medicines of value and ensuring efficient healthcare through objective, high-quality assessments. The main instrument used by NICE, the cost-per-Quality Adjusted Life Year (QALY), can be a crude measure of value, in that it imposes an arbitrary, population-based barrier to access for individual patients with varying needs.

32. GSK believes therefore that there is a case for broadening the definition of value. The cost per QALY should not be used as the only criteria for decision-making. A broad range of clinical outcomes and societal factors that have a real impact on patients and carers should also be part of the formal assessment.

33. In addition, the current cost-effectiveness threshold (£20,000–£30,000) should be reviewed. Consideration should be given either to increasing it, or assessing how it is applied, perhaps considering other aspects such as areas of significant unmet medical needs, UK health priorities, or a convergence with other government targets such as increasing the number of patients being treated in Primary Care as opposed to in hospital.

34. Developing innovative medicines in oncology presents unique challenges, and yet it appears that when they become available, many are rejected on the grounds that they do not represent a good use of scarce NHS resources. This decision appears to unfairly disadvantage UK patients and is contrary to the principles of providing a world-class national health service. It also has the potential to develop an inequitable system where a patient's access to medicines is dependent on their ability to pay. This is in contrast to the French philosophy for example, which recognises the value of improvements in survival even in the late-stages of cancer, to both patients and their relatives. Medicines such as Avastin have received high ratings for additional medical benefit (ASMR) leading to rapid uptake in patients in France.

EFFECTIVENESS OF SPECIFIC INTERVENTIONS, SUCH AS HEALTH ACTION ZONES, TO ADDRESS HEALTH INEQUALITIES AND THE DISTRIBUTION OF GP SERVICES & THEIR INFLUENCE ON HEALTH INEQUALITIES

35. Whilst this issue does not fall within GSK's core business experience, we recognise that the government is undertaking many activities aimed to impact the distribution of GP services specifically to address the potential of this to exacerbate health inequalities. For example, in 1998, the government introduced Health Action Zones, in which some of the most deprived areas of the country received extra funding to improve health by targeting poor housing, poverty and unemployment.

36. More recently, the government has introduced Practice Based Commissioning (PBC) to further reduce health inequalities by enabling budget holders to tailor their services to local demands. GSK welcomes this principle as, in theory, it should lead to more empowered patients, who have choice and control over the services they require. This in turn should result in a reduction in health inequalities, with informed investment decisions based on evidence. GSK is currently engaged in partnering with PCTs to help construct long-term solutions for their local GPs who will be responsible for managing budgets. This requires a shift in current thinking towards planning over longer cycles and linking appropriate medicine use and service provision with explicit health outcomes.

37. One concern about outcomes is that they should be appropriately targeted. Whilst decreasing the overall number of smokers in the UK is a positive outcome, as noted above, it may not reduce health inequalities¹⁷. In the event that PCTs only have a numeric target for the overall number of smokers who quit in their area, they may well target those groups with higher success rates, rather than those in lower socio-economic groups who are less likely to succeed. Specific targets in priority groups should be developed for PCTs with outcome assessment being monitored on these targets.

SUCCESS OF NHS ORGANISATIONS AT COORDINATING WITH OTHER ORGANISATIONS AND OF DH IN COORDINATING WITH OTHER GOVERNMENT DEPARTMENTS

38. GSK is not in a position to comment on the whole scope of coordination activities undertaken by either NHS organisations or the DH.

39. An example with which we are cognisant however relates to the work undertaken in relation to the introduction of the Smoke Free legislation where the DH worked with local authorities and the Chartered Institute of Environmental Health (CIEH) across the country to effectively train Environmental Health & Trading Standards Officers to ensure that the implementation of this new legislation was consistent across the country.

¹⁷ "Smoking and smoking cessation in England: Findings from the Smoking Toolkit Study", Robert West, University College London, London, October 2007. Presentation can be found on <http://www.smokinginengland.info/>

40. In addition, Public Funds Scrutiny was undertaken to maximise the benefits of the legislation in terms of a coordinated approach to support smokers who chose to make a quit attempt as a result. This activity appeared well-structured and organised. Bodies such as the Smoking Control Network received positive feedback from a range of stakeholders about the results of this throughout England.

41. GSK recognises the WHO FCTC recommendations as having proven impact on reducing smoking prevalence. GSK therefore recommends the following approaches which will require cross-governmental working to implement:

- raising taxes on cigarettes at above inflationary rates;
- enhancing health warnings on cigarette packaging;
- including visual health warnings on cigarette packaging;
- increasing action against smoking of smuggled tobacco; and
- harmonisation of European taxes on tobacco to the highest level.

42. Recent legislation to increase the age limit to purchase cigarettes to 18, in order to reduce the uptake of smoking by teenagers, needs to be supported by restrictions on the sale of cigarettes through vending machines to minimise the access of teenagers to this potential source.

43. The 2007 Budget reduced the VAT rate on over the counter (OTC) Nicotine Replacement Therapy (NRT) to 5% for 1 year from 1st July 2007. As one of the reasons the less well off do not access OTC NRT is price, GSK recommends maintaining the current low VAT rate beyond 30th June 2008 (current expiry date). This recommendation is in line with recommendations from the European Parliament to increase access to NRT across Europe through applying low VAT rates.

GOVERNMENT'S LIKELIHOOD OF MEETING ITS PSA TARGETS

44. The DH appears to acknowledge that they are unlikely to meet their PSA to reduce smoking in Routine & Manual Workers to 26% but aim to focus further on this in 2008–9. In order to achieve this and other health inequality targets, the DH must maintain its marketing and communications activity to inform and educate the public on living healthily. Any programmes undertaken should also receive long term commitment by national and local health services as, with the example of Ireland in relation to smoking cessation, many public health issues re-emerge if such commitment and programmes are not undertaken.

December 2007

Memorandum by Dr Richard Cookson (HI 05)

THE CONTRIBUTION OF THE NHS TO REDUCING HEALTH INEQUALITIES

I have three suggestions, all of which relate to primary care.

1. Additional financial incentives for GPs to re-locate in deprived areas with a relatively low number of GPs per head of population. Current incentives (eg LISI payments) have failed to achieve geographical equity of access to GP services, as deprived areas remain demonstrably under-doctored compared with affluent areas. This geographical inequality is associated with, and a probable cause of, well-documented socio-economic inequalities in the use of hospital services such as hip replacement and revascularisation. GPs have always had powerful personal and professional incentives to locate in affluent areas—ie, to put it rather crudely, a nicer home environment and an easier caseload. The QoF scheme adds an additional perverse financial incentive, since it is easier to score highly on any given target for treatment “quality” with relatively advantaged patients who actively request the latest treatment and comply with it. These perverse incentives need to be countered if this fundamental, long-standing and persisting geographical inequality of access to health care is to be remedied.

2. New QoF incentives to encourage case finding of disadvantaged individuals for cost-effective QoF interventions such as statins and smoking cessation therapy. Under current QoF rules, GPs have perverse incentives not to case find disadvantaged individuals. This is because (i) case finding is labour-intensive, (ii) disadvantaged individuals often cost more to treat due to co-morbidity, and (iii) meeting any given target for treatment “quality” is harder to achieve due to non-compliance issues. Without incentives to case find, disadvantaged individuals will continue to have a relatively low take-up of life-prolonging preventive health care interventions. These new incentives could take the form of a payment to the GP practice for each new case diagnosed among their disadvantaged patients, to compensate for case finding effort. More radically, the new incentives could also include a conditional payment to the disadvantaged individual in question to encourage compliance (eg using the existing LISI scheme to identify an individual as “disadvantaged”). However, any patient compliance incentives would need careful design and piloting, as it is easier to monitor compliance with some treatments (eg statins) than others (eg smoking cessation)—and, unfortunately, the areas where compliance is hardest to monitor tend to be areas where monitoring is most needed. Nevertheless, with imagination some sensible pilots could be designed.

3. Re-design QoF incentives to improve cost-effectiveness—ie more health gain per pound spent—in the following three ways:

- (a). Add selected new indicators with low expected cost per QALY (ie high health gain per pound spent) compared with existing indicators.
- (b). Reduce payments to zero while retaining current data collection requirements for selected existing indicators with high expected cost per QALY. The requirement to maintain current data collection requirements is crucial since (i) it maintains a “peer comparison” incentive to continue performing well (some studies suggest that “peer comparison” incentives can be powerful, independently of financial incentives) and (ii) it allows gathering of much needed evidence to inform the design of future incentive schemes—are quality gains maintained once financial incentives are withdrawn?
- (c). Strengthen incentives for additional quality improvements, for the same incentive payment expenditure, by abolishing the upper payment threshold and reducing payments per point to achieve cost-neutrality. Announce the payment per point AFTER the quality scores are in and calculations have been made, to achieve cost-neutrality.

Richard Cookson
University of York

January 2007

Memorandum by Diana Moss (HI 06)

THE ROLE OF THE NHS IN REDUCING HEALTH INEQUALITIES

Response to request for evidence of the effectiveness of public health services and how well the NHS links with local authorities, education and housing providers.

As a public health nurse, over the past six months I have been delivering both The Royal Institute of Public Health Level 2 Award “Understanding Health Improvement” and Train the Tutor events nationally for the same.

My experience is that this programme is acting as a catalyst and vehicle for Primary Care Trusts, local authorities and non-statutory organisations to work together in effecting health behaviour change in areas of deprivation and inequality.

Evidence of positive outcomes as a result of the level 2 award “Understanding health improvement” in Derbyshire County PCT (a spearhead PCT) include the joint initiation of Health Trainers between the PCT and Leisure services, Housing schemes and local employers. Such Health Trainers and Associate Health Trainers act as sign posters and local support to members of deprived communities in making positive health changes. Changes include the initiation of food co-operatives, local support systems encouraging preventative physical activity (amongst ex-miners) and outreach support from housing associations.

In Cornwall and the Isles of Scilly PCT, similar initiatives in conjunction with Local authority social care services are providing support to communities subject to significant health inequalities.

In Lincolnshire joint work is underway with leisure services to provide local sign posters and support through the Health Trainer programme.

And in Cumbria (as well as elsewhere) the Prison services are planning to use the award as a route to enable offenders develop skills and understanding that on release, they may take back to their communities.

Local authorities themselves are interested in using this award in conjunction with local health service providers to promote health behaviour change in their own workforce (Taunton, Newham, Borough Council, Royal borough of Kensington, Chelsea & Westminster).

Using *Choosing Health* monies collaboratively to fund this award seems to be providing a route by which these statutory organisations are able to develop individuals employed by themselves, other organisations (e.g. CVS) and voluntary sector (eg Patient and public involvement groups) effect health change.

January 2008

Memorandum by Thames Ditton Women's Institute (HI 07)

IDENTIFICATION OF AN INEQUALITY IN ALLERGY TESTING IN GP SURGERIES

EXECUTIVE SUMMARY

1. In 2007, the Surrey Federation of Women's Institutes resolved to campaign for the return of allergy testing, especially for children, in all GP surgeries. Twenty years ago GPs commonly used allergy testing to confirm a diagnosis and to help patients identify and avoid triggers. By 1992, support for this clinical investigation in asthma management was withdrawn. Despite reversal of the policy three years later, today only 4% of GPs make allergy testing available to their patients. In consequence, most allergic disease is treated with drugs, with little attention being paid to establishing triggers or avoidance techniques.

2. The 2007 House of Lords' report *Allergy* stated that approximately 1 in 9 of the population are diagnosed with an allergic disease at some time. The fact that so few GPs offer these patients allergy testing represents an inequality in primary care that needs to be reversed to help tackle UK's noted allergy epidemic. All GPs should be offering this simple cost-effective investigation because, without the knowledge of allergy triggers, patients and doctors alike are disadvantaged when seeking solutions.

3. The WI Resolution not only highlights the inequality in allergy testing, but also describes an NHS solution. It calls for local Primary Care Trusts to become involved in allergy management, including allergy testing and patient education, and that the findings from the investigation be referred back to the patient's GP to form a "loop" of healthcare. A visiting allergy specialist nurse, funded by PCTs, could perform this task within GP surgeries thus saving disruption in the lives of the patients, cost to hospitals and consultants' fees. One simple allergy test (skin prick) costs the NHS 15p

4. Women from Thames Ditton WI will be presenting their Resolution and petitions from WI members across the country to the Prime Minister at Downing Street in late January.

BACKGROUND INFORMATION

5. Allergy testing, to confirm a diagnosis of an allergy or allergic disease, was established long before 1989 when a medical consensus on asthma management stated, "Skin prick tests and/or total IgE concentration may be useful in some children to reinforce a possible diagnosis of causes of asthma." This publication was part 1 of 2 of the first British Thoracic Society (BTS) Guidelines on the Management of Asthma.

6. In 1992, when the Guidelines were revised, support for allergy testing was largely withdrawn; "Skin prick tests and in vitro specific IgE measurements are rarely helpful in diagnosis and management and results should be interpreted by a physician familiar with such tests".²

7. The results of the policy change took allergy testing away from the domain of the family doctor and placed it in the hands of consultants. This meant that GPs were diagnosing an allergic disease without identifying triggers and, in some cases, a delayed diagnosis being made.

8. In 1995 the BTS Guidelines were again revised with support for allergy testing reinstated, "skin prick testing with relevant allergens can be helpful . . ."

9. Today there is no doubt as to the importance of allergy testing, indeed it has been called the "Cornerstone of Allergy Diagnosis" by opinion leaders in allergy. The loss of support by the BTS Guidelines in the early 1990s may have crippled the confidence of clinicians to perform allergy testing in primary care, but the lack of funding to encourage this procedure in all GP surgeries has been truly devastating.

SUGGESTED SOLUTIONS

10. A greater use of Primary Care Trusts (PCT) to help allergy patients identify triggers through allergy testing would be welcomed. According to the House of Lord's Report *Allergy*, most PCTs fund school nurses. Extending this primary care role into funding visiting allergy specialists available to all GP surgeries, is one possible solution for the NHS in tackling the allergy "epidemic". This course of action was identified in the WI Resolution on Allergy

How may this be achieved?

11. A visiting allergy specialist nurse working closely with a referring GP could:

- (a). Test and educate patients in allergen recognition and avoidance techniques
- (b). Improve health through allergen avoidance combined with properly prescribed medication
- (c). Encourage self-management of health, especially in chronic allergic diseases
- (d). Lessen disruption of family life, work or school by being easily accessible

- (e). Reduce time spent in GP surgeries seeking allergy treatments
- (f). Most importantly, establish a holistic picture of the patient for GP feedback and review to be updated as required

12. The visiting allergy specialist nurse could extend influence beyond advising patients on allergen avoidance. They can record and monitor changes in patient's stress levels, home and work environment, diet, exercise and quality of life.

13. Doctors have found that only 4% of GPs offer allergy testing to their patients. This statistic represents an inequality in healthcare that is not by postcode but extends across the country and needs to be remedied in the interest of public health.

14. THREE SUPPORTING DOCUMENTATIONS

1. The Surrey Federation of Women's Institutes Resolution on Allergy (passed, AGM March 2007). (Annex A)
2. Example of the SFWI Petition (signed)¹⁸
3. www.actionforallergy.org. A website that contains two short video clips by Drs Glenis Scadding and Jill Warner. To support the WI Resolution, a link to the site was posted on the Surrey Federation section of the National Federation of Women's Institutes website and remains there to date.

Nell Nockles,
on behalf of Thames Ditton Women's Institute

January 2008

Annex A

Submission of a Resolution by Thames Ditton WI—Passed 16 May 2006

Passed by member of Surrey Federation of Women's Institutes March, 2007

RESOLUTION

In view of the increase in allergy related health problems we call upon H M Government to make funds available for allergy testing, especially for children, in all GP surgeries

INTRODUCTION

In the UK, doctors report that allergy and allergic disease have reached epidemic proportions and that the NHS is not coping with demand for allergy treatments. They also report that children are the most vulnerable social group with many suffering from a combination of allergic disease symptoms. With too few allergy consultants available, busy GP's turn to drug remedies with little attention paid to identifying allergy triggers or developing effective allergen avoidance programmes. In order to remedy this situation doctors propose setting up a national network of fully staffed allergy clinics to treat symptoms, educate patients and inform NHS healthcare workers on the latest treatments and remedies. We believe there may be a more cost effective and immediate solution. Once an allergy trigger is clinically identified through testing in GP surgeries, doctors could refer patients to the local Primary Care Trusts in order to develop a personalised allergen avoidance programme and report progress back to the referring GP. Once established, the healthcare loop could encourage patients to self-manage their condition while recording an allergy and life style profile for the surgery's records as allergic conditions are known to alter through stress, environment, age and events.

The Allergy Epidemic

Allergic disease affects about one in three in the UK population with children bearing-the-brunt of asthma, eczema, rhinitis, and conjunctivitis. In 2003, the Royal College of Physicians (RCP) published a report stating that allergy and allergic disease had reached epidemic proportions and that the NHS was not coping with demand for healthcare. In highlighting the rise of childhood allergic disease the doctors noted that, "In 13 to 14 year old children, 32% report symptoms of asthma, 9% have eczema and 40% have rhinitis" and that, "The UK ranks highest in the world for asthma symptoms, and is almost top for allergic rhinitis [hay fever] and eczema." Addressing the cause of the rise they identified genetic susceptibility and our changing life style and environment; "Increased exposure to allergens and air pollutants, over-use of antibiotics and other drugs, reduced fruit and vegetable intake, reduced early life exposure to bacterial products, and an alteration in bacterial colonization of the gut, have all been blamed". The RCP also noted

¹⁸ Not printed.

a major shortage of allergy specialists, with only six fully staffed allergy clinics available in the UK and approximately one allergy consultant per 2 million of the population. No NHS allergy specialists centres exist West of Bournemouth or North of Manchester, allergy testing is poorly funded, consequently most allergic disease is treated with drugs with little attention being paid to establishing the cause of the allergy or developing allergen avoidance strategies.

The report put forward a comprehensive strategy to reduce the burden of allergy on society through the setting up of a nationwide network of allergy centres fully staffed with at least four specialist consultants (2 adult and 2 paediatric) with appropriate support from specialist allergy nurses and dieticians. The new centres could also be training bases for primary care workers. The centres would be especially helpful for patients who are diagnosed with multiple allergic diseases affecting either lungs, nasal passages, eyes, skin or gut. Many of these “multi-presenting” patients are children who often receive “fragmented” specialist care leading to “steroid loading” treatments that risk unacceptable side effects including growth retardation. Approximately 10% of children diagnosed with allergic disease are in this multi-presenting category. The House of Commons Health Committee reviewed the RCP Report in 2004 and endorsed most of its recommendations calling for the Government, “to produce a strategy document to show that it really is serious about tackling the disease burden. The Government has agreed there is a problem but hasn’t yet faced up to it. At the moment, the NHS is not a national health service at all so far as allergy is concerned.”

Considering the RCP Report and the Health Committee’s recommendations, there is a clear urgency to remedy the situation. To remain passive while waiting for the Government to weigh up the cost of the clinics to the taxpayer and seek approval for funding before putting the wheels in motion to establish the clinics is not responsible citizenship, nor is it in the interest of public health, especially child health. We believe there is an alternative pathway.

What can be done?

We suggest a greater use of Primary Care Trusts (PCT) to help shoulder the responsibility of reducing allergies in the UK. PCTs were established by the Government to support GP surgeries, encourage patients to self-manage their health, improve quality of life and to react to local public health concerns. By expanding their area of responsibility to create personalised allergen recognition and avoidance programmes for patients, they can help to ease the burden of allergy on the community. The PCTs could initiate group sessions designed to inform, encourage and empower patients to self-manage allergy conditions. Furthermore, we suggest that major causes of allergy including moulds, pollens and mites, be studied at schools, thus encouraging a greater understanding of the environmental causes of allergy.

How may this be achieved?

Avoidance of clinically identified triggers is universally recognized as the first step in allergy treatment and there is good clinical evidence that patient education alone can bring about health improvements in allergy and quality of life. A qualified primary care worker could help to realize this aim by;

- Educating patients in allergen recognition and avoidance techniques
- Encouraging self-management of health, especially chronic allergic disease
- Reducing symptoms by reduced exposure to triggers
- Lessen disruption of work patterns, family life, or schoolwork.
- Reduced time spent in GP surgeries seeking allergy treatments
- Establishing a holistic picture of the patient for GP feedback and review

The educational package created could extend beyond the commonly known environmental triggers (see below) to include other factors that can make allergic reactions worse. They include stress, emotional state, overall state of health, workplace environments or ingestion of food or food additives. One of the more puzzling aspects of allergy is that reactions can happen many hours after exposure to a trigger. In this case, good detective work by the patient is required to identify the offending allergen. An informed patient will have a better chance to understand and control adverse events such as late reactions and personal “events” that can make allergic conditions worse.

Common Causes of Allergy in Children and the Target Organ				
1. Gut	2. Skin	3. Lungs	4. Nose	5. Eyes
Egg White	All of 1. plus	Mites	Mites	Moulds
Milk	Mites	Moulds	Pets	Pets
Soy	Animal skin	Pets	Moulds	Mites
Peanuts	Pollens	Cockroaches	Pollen	Pollen
Wheat	Cockroaches	Pollens		
Fish	Fruits	Animal skin		
Nuts				

All of these allergy triggers are largely avoidable. A blood test or skin prick test will help to identify the allergens responsible for reactions and once identified the patient or the patient's guardian can take steps to avoid exposure. Imparting this information in order to encourage self-management of health is a primary health care concern and PCTs are perfectly placed to take up this challenge. Considering the urgency to reduce the burden of allergy on society, the community teams could be utilized to spearhead this area of healthcare.

Patient's Financial Considerations

The cost of purchasing recommended protective devices, such as bed covers against mite infestations, may be considered "expensive" and discouraging for many patients. Therefore, we recommend that the Government should create an incentive that would encourage patients to become actively involved in allergen avoidance. A scheme, such as a tax incentives for protective measures, could act as an incentive for patients who otherwise might be reticent in taking steps to guard against allergen exposure.

Resulting benefits

The benefits would be a better-informed patient with a direct communication link to his/her GP's surgery whose role is to maintain a current perspective of the patient's overall welfare. An allergen avoidance programme, specifically designed for the patient from allergy testing could help control the symptoms of chronic asthma, rhinitis, eczema, or conjunctivitis. The resulting overall health gains will prove beneficial to society as a whole as an enlightened public acts to self-manage health through practical and evidence based information. The current cost to the Nation of allergies is unacceptable; with developing children most at risk from allergy symptoms.

It is timely for WI members to act and campaign to reduce the emerging UK allergy "epidemic" by calling for allergy testing to be made freely available in all GP surgeries and allergen avoidance education to be made available through Primary Care Trusts. The Campaign could begin by petitioning the eleven members of Parliament who represent the people of Surrey.

RECOMMENDATIONS FROM THE HOUSE OF COMMONS HEALTH COMMITTEE'S REPORT ON ALLERGY

"We recommend that a network of primary care allergy providers be created with a named lead for allergy in each Primary Care Trust. We ask for improved incentives for GPs to treat allergy and for better training. We recommend that a framework is developed to facilitate the introduction of allergy into the GPs with Special Interest programme, and for the Department of Health (the Department) to support this initiative."

FOR REFERENCE:

The Royal College of Physicians Report (2003) "*Allergy-the unmet need: a blueprint for better patient care*" The Lavenham Press, ISBN 1 86016 183 9.

"*Stolen Lives -The Allergy Report*" The Impact of Allergies On People's Lives In The UK Today. Allergy UK—May 2003. www.allergyuk.org (open "Home Page" then seek "Features" scroll down to "Stolen Lives").

The UCB Institute of Allergy. European Allergy White Paper; *Allergic disease as a public health problem*. Braine-l' Alleud: UCB Pharmaceutical Sector, 1997.

House of Commons Health Committee's Enquiry into "*The Provision of Allergy Services*". Published November 2nd 2004, The Stationery Office Limited, HC 696-1.

For information and advice please contact;

British Allergy Foundation, www.allergyfoundation.com

The Anaphylaxis Campaign, e-mail: info@anaphylaxis.org.uk

Asthma UK, www.asthma.org.uk.

National Eczema Society, www.eczema.org

Memorandum by McCain Foods (GB) Ltd (HI 08)

THE CONTRIBUTION OF THE NHS TO REDUCING HEALTH INEQUALITIES

1. EXECUTIVE SUMMARY

1.1 Based on long experience and close understanding of both the dietary behaviour of SEGs particularly prone to diet-related health inequalities and the challenges faced by school caterers—and on a sound record of innovation to improve both product information and staple food products' nutritional value, McCain Foods (GB) believes that the Health Committee should consider the following steps to address diet-related health inequalities:

- Recommending that the DoH places the message of encouraging individuals to switch from “less-healthy” to “more healthy” foods within popular staple food categories at the centre of dietary advice intended to counter growing obesity.
- Recommending that the DoH takes clear leadership within Government to ensure that all initiatives intended to counter obesity—including changes to school food—have unambiguous objectives, are evidence-based, are proportionate and do not have unintended, counter-productive outcomes.

2. INTRODUCTION

2.1 McCain Foods (GB) welcomes the opportunity to contribute to this important Inquiry. Health inequalities are rightly a source of political and social concern. Among the principal causes of health inequalities are those relating to dietary factors and the effect of those dietary factors upon health outcomes. The differential incidence of obesity by socio-economic group (SEG) naturally has a strong correlation with the incidence of those diseases closely associated with obesity among those same SEGs and the consequent impact that those diseases have upon healthy life-years. As a major manufacturer of popular staple foods, we believe that we have a close, if not unique, perspective on the part that food manufacturers can play in supporting Government efforts to reduce those health inequalities attributable to diet.

2.2 While this Inquiry focuses particularly on the role of the NHS in addressing health inequalities, we would like to make short contributions on two particular areas of the Inquiry where we believe our perspective and experience can offer a view that adds value to the Committee's deliberations. These relate to the need, as part of the Governments plan to address obesity, for the Department of Health to:

- focus on helping individuals make incremental, but practical and achievable changes to their diets
- ensure that the detail of regulation of school food by DCMS supports, rather than negates the aim of overall policy in that area

2.3 By way of introduction to ourselves, McCain Foods (GB) Ltd is the UK & Ireland entity of McCain Foods, a family-owned company based in Canada since 1957 and now operating in 100 countries worldwide. We have been present in the UK since 1968 and operate 5 food manufacturing plants in England and a farming operation in Scotland, employing a total of 2000 people and buying 12% of the UK national potato crop. While we manufacture for the foodservice and private customer sectors, our main business and that for which we are best-known is the manufacture of branded retail frozen potato products principally designed for cooking by baking in the home oven. Our principal brands include Oven Chips, Home Fries and Home Roasts.

2.4 Since entering the UK market, McCain has revolutionised the way the nation eats potato products; effectively marginalising the “chip pan culture” by introducing a wide range of convenient, lower-fat, oven-bakable potato products. We have innovated continuously to make our products more convenient and better for our consumers. We have reduced added salt in our products by 18% since 2001 and, by adopting the use of sunflower oil, have reduced the levels of saturated fat by 70% since 2005. We have improved consumer information by becoming the first food manufacturer to adopt the Food Standards Agency's “traffic light” nutritional labelling format, along with GDA information on all our retail packs. Our new Oven Chip Rustics and Rustic Roast potatoes recently became our first products to qualify for four “green lights” under this labelling system. We see the way forward for our company as one of making further developments to our product range that enhance the choice of nutritionally balanced products available to household consumers.

2.5 The extent to which these products accord with modern preferences for convenience and nutritional profile is shown by the fact that there is a McCain product in 75% of household freezers. We already have a powerful reach into the type of SEG which is particularly vulnerable to health inequalities—around 40% of our consumers come from C2 or D groupings. But we believe that the potential of better-for-you staple products such as ours in leading dietary change is currently underplayed by certain quarters of Government and would now like to turn to the two areas of focus for the Inquiry where we would like to contribute:

“The effectiveness of public health services at reducing inequalities by targeting key causes such as smoking and obesity, including whether some public health interventions may lead to increases in health inequalities and which interventions are most cost-effective”

2.6 In respect of this question, we would like to suggest that supporting and encouraging members of the SEGs which are most likely to experience health inequalities to make simple, readily acceptable and sustainable long-term changes to their dietary habits is likely to prove one of the most cost-effective and enduring of the possible public health interventions affecting diet and obesity. The long-term effectiveness of short-term special diets is a debatable subject and exhortations to people to make radical longer-term changes to their diet tend to founder on the grounds of the affordability, accessibility and—most importantly—the consumer acceptability of the changes suggested to dietary regimes and shopping baskets. However, the perhaps more realistic goal of educating people to move—largely within their existing diets—away from less-healthy choices towards more-healthy options, within the context of gentle changes to the overall amount and balance of food consumed can both begin the process of changing behaviour at an acceptable and unthreatening level while immediately generating benefits to health.

2.7 Examples of such change might be promoting moves from butter to sunflower-oil margarines; full-fat milk to semi-skimmed; white bread to wholemeal etc. In our own product category, there are clearly nutritional benefits in encouraging a further shift away from the deep-frying in the home of potato products—chips etc.—towards an increased adoption of oven baking. A traditional deep-fried “chip pan” chip can contain up to 15%+ of frying fat whereas a McCain Oven Chip Rustic contains 3% sunflower oil.

2.8 The principle of advising individuals to seek out healthier options within food groups seems to have been widely accepted. Looking only at our own products, choosing oven chips over deep-fried versions is actively advocated by not only the Food Standards Agency (in their Healthy Eating Tips For Young People, in tips in their general advice column for both teenagers and mothers with babies, in their Guidance on food for adults in major institutions, in their Guidance on food served to older people in residential care and in their Advice on healthier catering) but also by the British Heart Foundation, the British Nutrition Foundation, Diabetes UK and the Food Commission. The NHS, in its Guide to Healthy Living, suggests just such dietary advice as does NHS Direct’s website.¹⁹

2.9 However, regrettably, there is an important exception. The concept of substituting “better” for “less good” foods is not mentioned anywhere within the Department of Health’s own healthier lifestyles campaign “Small Change, Big Difference”, despite the campaign’s stated intention to “encourage people to make minor changes in their lifestyles to give them a better chance of living longer, healthier lives”. The campaign fails, in its (limited) advice on diet, to include any reference to switching from less-healthy foods within food groups to better-for-you options, confining itself solely to advocating an increased consumption of fruit and vegetables.²⁰

2.10 We believe that it is a significant missed opportunity that the Department, which is primarily responsible for mass public education on diet and health, has in “Small Change, Big Difference” failed to embrace the principle of promoting small-scale, simple, dietary substitutions within food groups as a way of helping people take practical and realistic first steps towards tackling obesity and its concomitant health implications. We would advocate that a simple and cost-effective intervention would be for future messaging on “Small Change, Big Difference” or any other similar campaign that might stem from the forthcoming Government Plan on Obesity to “join up” with the dietary advice from the other agencies already mentioned, which lack the DoH’s communication budget and reach to audiences (both directly and through PCTs) in promoting this advice to all SEGs but in particular those most prone to dietary imbalances and thus to health inequalities.

“The effectiveness of the Department of Health in co-ordinating policy with other government departments in order to meet its Public Service Agreement targets for reducing inequalities”

2.11 We have set out in our evidence above one way in which the DoH could be more “joined up” in approach with other agencies of Government—particularly DCSF and the FSA and with other public health stakeholders in respect of the advice it gives about making changes to diet. Another area in which Government policy could be better joined-up in efforts to meet the PSA target relating to childhood obesity

¹⁹ <http://www.eatwell.gov.uk/agesandstages/teens/foodonrunp/>
<http://www.eatwell.gov.uk/agesandstages/teens/eatyourselfgorgeous/>
<http://www.eatwell.gov.uk/asksam/agesandstages/childrenandbabies/>
<http://www.food.gov.uk/multimedia/pdfs/institutionguide.pdf>
<http://www.food.gov.uk/multimedia/pdfs/olderresident.pdf>
<http://www.food.gov.uk/healthiereating/healthycatering/healthycatering04>
<http://www.food.gov.uk/multimedia/pdfs/cateringforhealthscot.pdf>
http://thebeat.bhf.org.uk/html/healthy_eating.html
<http://www.nutrition.org.uk/home.asp?siteId=43§ionId=598&subSectionId=325&parentSection=299&which=>
http://www.diabetes-insight.info/healthy_eating/DI_fat.asp
http://www.foodcomm.org.uk/children_food_poster.pdf
<http://www.nhsdirect.nhs.uk/articles/article.aspx?articleId=1133>
<http://www.nhs.uk/documents/NHSGHL%202005.pdf>
²⁰ http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Modernisation/Choosinghealth/Smallchangebigdifference/DH_4134044

levels (PSA Delivery Agreement 12, Indicator 3) is in respect of school food and in particular one aspect of the school food “Food-Based” Standards introduced by Regulation by DCSF in August 2007 but applied in schools informally since 2006.

2.12 Government policy is rightly to increase both the take-up and the nutritional value of school lunches and we support and applaud that objective. McCain has, for many years, been a well-established partner of school caterers. We have introduced a special for-schools range of “Alternative” potato products which are oven-bakable and meet Food Standards Agency nutritional specifications for levels of fat and saturates in manufactured school foods. We have piloted the introduction of enhanced steam convection ovens in schools, with proven nutritional, logistical and financial benefits. And, mindful of the fact that many schools have deep-fryers and insufficient oven capacity, we have promoted “Good Frying Practice” to help caterers produce optimum products using minimal fat.

2.13 We believe, on the basis of this experience—and our other commercial experience—that evidence proves that successful change to school meals needs to be a gradual and consensual process. Too-rapid, too-radical change poses the risk of estranging the customer—the pupils—and losing the opportunity to educate them about the qualities of, and how to choose, improved nutritional offerings. There are strong parallels here with change to retail consumer products, where we have discovered that it is possible to reduce salt levels incrementally over time, taking the consumer with us, as opposed to estranging them by removing salt all at once, whereupon the customer reverts to an alternative higher-salt product, generating no net health benefit.

2.14 It is apparent from the School Food Trust’s first two annual surveys of school lunch uptake in England that the introduction of new menus has not seen an increase, but rather a sharp fall—particularly in secondary schools—in pupils taking the healthier lunches; children choosing instead to eat takeaway food or consume packed lunches, both of unknown and uncontrollable nutritional worth. This, and other, SFT research, again, shows clearly that school caterers ascribe this fall-off in demand principally to pupils lack of enthusiasm for the new menus.^{21, 22} This is a regrettable and serious development. Not only is policy not being fulfilled if healthier menus are being offered but not, in fact, consumed—healthy meals are only healthy if they are eaten—but the fall-off in demand is endangering the viability of school meal services and, therefore, the provision of any school meals at all. Both developments, actual and potential, threaten to increase health inequalities as, for many children from SEGs most prone to diet-related inequalities, the school meal may be the only hot and healthy meal consumed during the day.

2.15 We would suggest that one, though not the only, factor in children’s distaste for the new meals is the lack of familiar and popular elements—such as potato-based staples—within the meals. The reason for the virtual absence of these foods is the fact that one of the “Food Based” Standards for school food classifies products that are briefly part-fried as part of their manufacturing process but finally cooked in an oven equally alongside foods finally cooked by prolonged immersion in the deep-fat fryer within a single definition of “deep-fried” food. “Deep-fried” products are restricted under the Regulations to service of a maximum of two portions per week. This Standard—which was initially justified by the School Food Trust (SFT) on the basis that it would “reduce fat in the diet”²³—does, then, classify a 15% fat chip-pan style chip deep-fried in the kitchen as identical to a 5% sunflower fat oven-cooked chip. Thus, any incentive to oven-cook chips rather than deep-fry them is removed, and so is any incentive to move towards oven-cooking in general, as many other products low in fat but cooked by oven-baking fall into the “deep fried” category. Examples include breaded fish and ethnic favourites such as samosas.

2.16 The practical effect of the Standard has been to ensure that chips and other potato favourites all-but disappear from the menu—the SFT have latterly conceded that this “cultural” objective was the real point of the rule²⁴—and to ensure that those that remain are more likely to be deep-fried rather than oven-cooked. Caterers, wanting to offer lower-fat potato staples as a familiar and benign element at the heart of a healthier new meal, find that they can do so only twice a week at most and that doing so means foregoing using any other “deep-fried” product.

2.17 We believe that the particular Standard governing “deep-fried” food is proving counterproductive and tending to increase inequalities by estranging children from adopting new, healthier, school menus. It does so because it confuses ends and means—it is not “joined up” either with wider dietary advice or, indeed, even within itself. FSA and NHS advice, as detailed in our first evidence point, is to encourage switching from less-healthy to more healthy options within food categories. This regulation does not aim to, nor does it achieve, such switching. The rule aims nominally to reduce fat but actively militates against caterers doing so. It, in reality, aims to restrict the visibility of a product, but seeks to do so by restricting a cooking method which it defines extremely widely.

2.18 A rational approach which fulfilled all policy objectives might instead be to focus not on cooking method but on nutritional outcome. Products should be judged strictly on their own nutritional composition—for instance, compliance with the FSA nutritional specifications for school products—and on their ability to fit within menus that meet the overarching Nutritional Standards. If there is a

²¹ http://www.schoolfoodtrust.org.uk/doc_item.asp?DocId=55&DocCatId=1

²² http://www.schoolfoodtrust.org.uk/UploadDocs/Library/Documents/ebdb_campaign_evaluation.pdf

²³ <http://www.schoolfoodtrust.org.uk/UploadDocs/Library/Documents/School-food-trust.pdf>

²⁴ Prue Leith, Chair, School Food Trust: Arena Lecture 12.2.07 “The Dangers of a Food Ignorant Society” (text available on request to originator).

supplementary desire to restrict the appearance of certain foods, such as chip-shaped products, then that could and should be made explicit. Standards based on this logic would help caterers produce meals which retained popular—but nutritionally compliant—products which children find familiar; They could too, if desired, still restrict the appearance of chips on school plates. Such a measure could help win children back from the cold lunchbox and high-street takeaway to the school dining hall which must be a positive outcome both per se and in terms of addressing health inequalities.

3. CONCLUSION

3.1 We hope that this evidence is of value to the Committee. The two points we have made are separate but have a common element; that by failing to discriminate between—and failing to encouraging others to discriminate between—foods of very different nutritional merit which fall within a category commonly (though very simplistically) often termed as “junk”, Government departments are inadvertently and indirectly contributing to inequalities in health outcomes. Adopting a more sophisticated approach which judges foods on their nutritional merits rather than their superficial appearance has the potential to educate, lead and enable people to make beneficial nutritional choices within their “comfort” zone of familiarity and thus have a wide and immediate impact on diet, particularly among those SEGs most prone to diet-related health inequalities. It would, too, motivate manufacturers of these types of food to innovate further to develop and market healthier options, in the knowledge that official advice would be to encourage consumers, at a generic level, to switch to healthier options. Our view is that DoH should take a lead in Government in this important area.

3.2 We would be pleased to have the opportunity to discuss these and any other points relating to our work as it impacts diet, health and obesity with the Committee.

January 2008

Memorandum by North West ASH (HI 09)

HEALTH INEQUALITIES

Smoking is more common in deprived communities. Attention to smoking is likely to reduce Health Inequalities but also needs to be targeted towards deprived communities.

PARAGRAPH 1

Reduction in active smoking and, second hand smoking is required.

Indeed smokers suffer even more from second hand smoke than their non smoking counterparts, as they are more likely to mix with other smokers and their risk from second hand smoke is added to their risk of active smoking.

So for example, children who are exposed to second hand smoke and then take up smoking themselves will then mix with other smokers, who will then have the highest risk of smoking related diseases.

PARAGRAPH 2

We must do more to protect children from smoking.

One obvious measure is to ban smoking in cars with children under the age of eighteen. The level of second hand smoke in a car with the windows open is equivalent to a passenger being in a smokey pub. Such legislation has already been introduced in California and, Norway.

Stopping smoking in cars with children should be used as a health campaign opportunity to draw attention to the dangers of second hand smoking in children. For example, in the home or, when pushing a pram.

PARAGRAPH 3

There is a need to extend the banning of smoking in public places.

For example, at outside tables at eating places, which are being served by staff and also at outside seating at sporting stadiums.

PARAGRAPH 4

The exemption of smoking on stage should be withdrawn.

This is clearly being abused, for example there was no reason for smoking at a recent Billy Elliot production. There was no artistic reason for this. There is no more reason to light up on stage than to commit a murder. Theatre requires suspension of disbelief. Actors can pretend to smoke just as they can pretend to commit a murder.

PARAGRAPH 5

Although there has been a recent reduction of VAT from 17.5% to 5% charge on Nicotine Replacement Therapy, it cannot be reduced further without agreement from the European Union. The British Government should press for complete abolition on VAT on Nicotine Replacement Therapy.

PARAGRAPH 6

Illegal tobacco is still a problem. Illegal tobacco is sold disproportionately in deprived communities. It should be made a priority for every crime reduction partnership.

It is relatively easy to detect, and many traders in illegal cigarettes will be committing other crimes, which, which may then also be detected. This activity should be supported by a National telephone line to report all instances of illegal trading. Although there is a National Crimestoppers telephone line, this would not be used for this. A dedicated line could be supported by the appropriate publicity.

Environmental health officers state that they only require the details so they can procure evidence, the caller would not have to give evidence in court.

PARAGRAPH 7

There has been a reduction of smoking on television.

This could go further, any smoking on television, especially before the 9pm watershed should have to be highly justified to the regulators.

PARAGRAPH 8

We know that access to cigarettes increases use.

Thus, the sale of cigarettes at the entrance of supermarkets are especially pernicious to the customer. There should be discussions with the supermarkets to stop this practice, but if they are not willing to co-operate then legislation should be considered.

As the issue of price and access is especially important to people of deprived communities these measures will help to reduce inequalities.

January 2008

Memorandum by Dr Gilles de Wildt (HI 10)

HEALTH INEQUALITIES, THE NHS AND PRIMARY CARE

This short submission on health inequalities focuses on primary care; monetary and non-monetary incentivisation; the role of the private sector; the choice for personal continuity of care; the role of health care in providing bridges to the excluded and marginalized, and in building "social capital" in a fragmented society.

This submission is based on front line health care experience in a deprived area; on academic work on commercialisation of care and on presentations and discussion on the subject at the annual conference of the RCGP in Edinburgh on 5 October 2007 and the Almamata Conference on commercialisation of health care on 24 November 2007 at University College London.

1. THE NHS AS A REDISTRIBUTIVE SYSTEM

The NHS remains a highly redistributive system. As UK society is much more unequal than most other countries in NW Europe, we need this more, also in view of the fact that other sectors are less distributive (eg education in the UK has a large private sector). Furthermore, the role of taxation and social insurance for redistribution is smaller as compared with Scandinavian countries and the Netherlands. The NHS is redistributive in spite of the “inverse care law” which stipulates that those in greatest need receive the least care^{25, 26}. The challenge is to correct the inverse care law.

2. THE NEW GP CONTRACT AND INEQUALITIES

The new GP Contract (also called GMS2) with its Quality and Outcomes Framework (QOF), has increased accountability and transparency and, arguably, overall resourcing of primary care. It has, however, worsened inequalities in provision. GPs and other members of primary care teams in deprived areas have to work harder to achieve the targets for monetary incentivisation in the QOF, for instance because many patients do not speak English and have more, and more complex disease. This can, in part, be redressed by changing the indicators and their value in QOF. The RCGP will present a submission with suggestions in this field. Significant imbalances may remain that are best addressed by (re-)allocation of resources. Before the introduction of GMS2, the NHS exercised the freedom to promote health care in deprived areas by developing infrastructure and by providing organisational support and non-monetary and monetary incentives for health professionals and ancillary staff. This can be done again, and can be done better. Examples where it is still done successfully are found in for instance Sweden and Norway. For its doctors in primary care, Sweden mostly relies on salaried GPs, while Norway has arrangements that are similar to the “independent contractor status in the NHS” held by GPs in the UK. Both countries have dynamic, forward looking, equity oriented health care systems that are highly valued and trusted by the public and offer excellent examples for the NHS. Furthermore, the NHS in Wales and Scotland have better retained instruments and arrangements that can facilitate the reversal of the inverse care law.

3. EQUALITY, MONETARY AND NON-MONETARY MOTIVATION.

It is important to note that much quality improvement in primary care took place before GMS2 was introduced and that the role of target based monetary incentivisation as a policy tool has limits²⁷, and may distort public health priorities, including the battle against health inequalities. Furthermore, most GPs (as many others in society) may not primarily be driven by the desire to maximise incomes or profit; there is an urgent need for the exploration of alternative sources of motivation for the delivery of quality care, including sense of ownership, and public service.

4. GPs, COMPANIES, PROFIT AND INEQUALITIES.

It is a misleading simplification to equate GMS2 and PMS GPs with for-profit companies. GMS2 and PMS GPs are highly regulated, anchored in communities, accountable, transparent, and not covered in their contracts by commercial secrecy. If the situation regarding hospital care is to be replicated²⁸, for-profit companies will be subject to a regulatory regime that will not allow comparison with the conventional NHS and that will deprive policy makers and the public of meaningful choice²⁹.

Also, for-profit companies can be sold on and go from hand to hand, including private equity firms, which is not the case in conventional General Practice.

While there is no denying that state or non-profit health care has its problems, involvement of the for-profit private sector is likely to considerably increase costs (including costs for shareholders, directors, management, PR, networking, lobbying and legal work)³⁰. Indeed, government is careful to avoid saying that privatisation is cheaper, rather suggesting that it may be more “efficient”.

There are moral problems as well as health risks when health care is based on markets and the profit motive. Bernard Shaw explained this a century ago in his Preface on Doctors³¹. More recently, the US health economist Kenneth Arrow, in his seminal essay³², pointed out that health care does not lend itself

²⁵ Tudor Hart J. The Inverse Care Law. The Lancet: Saturday 27 February 1971, 971; i: 405–412.

²⁶ Watt G. The Inverse Care Law Today. Lancet 2002;360:252–4.

²⁷ Roland M. The Quality and Outcomes Framework: too early for a final verdict British Journal of General Practice Volume 57, Number 540, July 2007, pp. 525–527(3).

²⁸ www.healthcarecommission.org.uk and: Day M. Failure to monitor independent centres prevents comparisons, says watchdog. BMJ 2007;335, p 173 (28 July).

²⁹ Day M. Failure to monitor independent centres prevents comparisons, says watchdog. BMJ 2007;335, p 173 (28 July). www.healthcarecommission.org.uk

³⁰ Vide: Drache D, Sullivan T (Eds). Health Reform. Public Success, Private Failure. Routledge, London 1999 and : Pollock AM. NHS Plc. Verso, London 2004.

³¹ Shaw GB (1909). The Doctors' dilemma, With a preface on Doctors. Accessed on 9/9/07 through: [http://etext.teamnesbitt.com/books/\(book 1560\)](http://etext.teamnesbitt.com/books/(book 1560)).

³² Arrow KJ (1963) Uncertainty and the welfare economics of medical care. The American Economic Review 1963; 53:941–73 Accessed on 9/9/07 at: <http://www.who.int/bulletin/volumes/82/2/PHCBP.pdf>

easily to the idea of a market for buyers and sellers. Health care is featured by asymmetry in knowledge between professional and patient—which is only partly diminished by easier access to online and other information-; on asymmetry in power (as in providing access to referrals and other resources), and by uncertainty. Health care delivery has to rely on trust in professionals, while the profit motive opens the door to exploitation, especially of vulnerable people, and the abuse of trust.

Dutch researchers observe that commercialisation of health care may lead to “organised distrust”³³. This was confirmed by US researchers who saw trust in health care organisations (HCOs) drop (followed by large scale efforts of community groups and legislators to counter the perceived untrustworthiness of HCOs)³⁴. UK researchers Coulson³⁵ and Goddard *et al*³⁶ observed that large monetary savings and organisational advantages arose from trusting relationships, even in the heavy contractualised NHS of the early 90s. These benefits are likely to be reduced or lost.

Commercial logic, also insisted upon by investors (including banks and pension funds), encourages profit-maximisation, although for the purpose of image and Public Relations, statements may be made that suggest that corporations are charitable³⁷.

A core strategy for profit maximisation in health care is risk identification, risk selection and the avoidance of care for very ill or otherwise costly people, which will disproportionately affect deprived populations. Edwards, of the NHS confederation, reports the risk of “cream skimming, dumping and skimping”³⁸. US evidence confirms this phenomenon^{39, 40, 41}. Recent UK evidence shows that Mercury Health (now sold and called Care UK), a diagnostics company contracted by the NHS in and around the Midlands, was allowed by the NHS to not provide transport to its diagnostics facilities, while the conventional NHS does⁴². Mercury Health thus avoided poor and frail patients, who require significantly more resources and higher costs, for instance in terms of staff time, explanation of procedures, extra hands to help wheelchair bound patients, etc.

5. PROTECTING EQUITY: BEYOND “LIGHT TOUCH REGULATION”

A great deal of investigatory and regulatory power is needed to unearth and correct practices that undermine quality and equality, and that may partly be covered by “commercial confidentiality” or “secrecy”. The current UK culture of “light touch regulation” may be wholly inadequate. Overseeing bodies must not only have powers to investigate current practices, but also to assess the effects of proposed and current policies on quality and equality, eg by commissioning independent health and equality impact assessments (something the health care regulator in the Netherlands may do).⁴³ Overseeing bodies also require strengthened statutory independence and Scandinavian style, authoritative rules on competing interests.

6. CAREFUL USE OF THE PRIVATE SECTOR OR RUNAWAY FOR-PROFIT PRIVATISATION?

Government proposes that judicious use of the private sector (for-profit and nonprofit) can help reduce health inequalities. There are four problems. First, as mentioned earlier, strong commercial incentives exist for “skimming dumping and skimping”, while US evidence confirms that for-profit involvement undermines rather than promotes equity by disadvantaging deprived populations. Second, nonprofit entities are fundamentally disadvantaged *vis-à-vis* corporations when preparing for the costly and time consuming tendering process. Third, there is the risk of runaway for-profit privatisation. Once tendering processes start, European and other competition law may prise open all or most services for for-profit contracting, according to experts interviewed in the Financial Times⁴⁴. Fourth, the higher costs and the greater degree of legal entrenchment to protect profits may reduce the flexibility required to address changing inequalities in health; a flexibility that was typical of the conventional NHS.

³³ (in Dutch) Hilhorst MT, Struijs AJ Commerciële normen in de zorg: marktmechanisme heeft invloed op beroepsethiek. (Commercial norms in health care: market mechanisms influence professional ethics) Medisch Contact 25/5/05

³⁴ Vide: Mechanic D (1996). Changing medical organization and the erosion of trust. *Milbank Q.* 1996;74:171–189 -Mechanic D, Schlesinger M (1996). The impact of managed care on patients' trust in medical care and their physicians. *JAMA* 1996;275:1693–97. -Mechanic D (2004) In my chosen doctor I trust. *BMJ* 2004;329:1418–9 (18 December).

The perceived lack of trustworthiness of US health care organizations (HCOs) was countered by public interest groups and elected representatives by bringing laws on to the statute books that require HCOs to disclose hitherto secret incentives for doctors and gagging clauses for employees. By the end of the century, more than 1000 such laws had passed at State level. (vide: Mechanic D (1998) The functions and limitations of trust in the provision of medical care. *Journal of Health Politics, Policy and Law.* 23;4:661–85).

³⁵ Coulson A (Ed). *Trust and Contracts: Relationships in Local Government, Health and Public Services.* Policy Press, Bristol, 1998.

³⁶ Goddard M, Mannion R From competition to co-operation: new economic relationships in the National Health Service *Health Economics.* Volume 7, Issue 2, Pages 105–119.

³⁷ Vide Robert Reich, US Government Minister of Labor under President Clinton: Reich R B. *Supercapitalism The Transformation of Business, Democracy, and Everyday Life* Alfred A. Knopf, New York 2007

³⁸ Edwards N (2005) Using markets to reform health care. *BMJ* 2005;331:1464–6.

³⁹ Needleman J (2001) The Role of Nonprofits in Health Care. *Journal of Health Politics, Policy and Law.* 26.5: 1113–1130.

⁴⁰ Pollock A. NHS PLC. Verso, London 2006.

⁴¹ Woolhandler S, Himmelstein DU. Competition in a publicly funded healthcare system. *BMJ* 2007 335: 1126–1129.

⁴² Personal Observation, Dr de Wildt, GP, Jiggins Lane Medical Centre, Birmingham.

⁴³ Netherlands Health Care Inspectorate: www.igz.nl/uk

⁴⁴ Timmins N. European Law Looms over NHS Contracts. *Financial Times* 16 Jan 2007.

7. FOR-PROFIT PRIVATISATION, PERSONAL, CONTINUOUS HEALTH CARE AND INEQUALITIES

Patients place high value on the option to choose personal continuity and to see a Doctor or nurse (or a limited number of Doctors and nurses) they know and trust⁴⁵. Many exercise this choice. Indeed, research confirms the importance of personal continuity and familiarity, especially, but not only, for patients who are less articulate, and patients who have serious or chronic illness⁴⁶, disproportionately affecting deprived populations. Familiarity or continuity may be historical, as in trusting the health care professionals who helped look after a dying grandmother.

There is strong evidence that familiarity and continuity lead to higher patient satisfaction, as well as evidence that it leads to better outcomes, although the latter is subject of academic debate. This should not impede choice. Contrary to impressions that there is a lack of choice for patients, in urban areas most patients can choose between a number of practices⁴⁷, and many exercise that choice.

8. CHOICE, CONTESTABILITY, RESPECT AND INEQUALITY

For-profit commercialisation and contestability will fundamentally change the relationship between patients, doctors, nurses and other primary care staff. Short contract cycles will encourage employees, including doctors, to plan for the short term only and to keep an eye on greener pastures. The sense of emotional (and now often also material) ownership of a GP practice, public service and the sense of belonging to a team that is anchored in a community and in it for the long term will be reduced if not totally lost. Opportunities for patients to develop relationships that are characterised by familiarity and personal continuity of care will be much more limited. Furthermore, the—modest but important—contribution of primary care to the development of “bridging” social capital⁴⁸ will be reduced. Primary care health professionals and their teams offer low threshold access, familiarity and the possibility of developing long lasting, trusting relationships⁴⁹, options usually not otherwise available to the marginalized, excluded and deprived.

Questions must be raised as to the appropriateness and narrow application of ideologies that promote “contestability and choice”⁵⁰ and a consumerist approach in health care. Many (including the author of this submission) accept that there is an important but limited place for consumerism in health care. It may well suit a number of patients during important phases of their lives, when they have only limited health care needs. At the same time it must be noted that most consultations (involving the most needy patients) are not of a consumerist nature, but are characterised by the exchange of complex information, the exploration of patients’ wishes, vulnerability (often turning into dependency), medical management options and helping patients to make sense of their condition, aided by professional expertise and trusting relationships.

The London and New England based academic Richard Sennett⁵¹ warns that ideologies such as choice and competition, associated with a consumerist approach, engender disrespect for those who cannot or do not wish to reach the “top”, or for those who need or want a more relational and cooperative approach in their lives. Indeed, he observes that many elites, including policy elites, now see themselves as the norm for everyone. In health care, this approach threatens to disadvantage the more needy and deprived sections of the population and undermine equity. It is essential for the development of equity-oriented public policies that the ideology of “choice and competition” and its application to society (and health care in particular) are scrutinised by parliament and the public at large.

9. SUMMARY POINTS AND POLICY OPTIONS

- For-profit privatisation and short term contracting is likely to worsen inequalities, increase costs, reduce options for personal continuity of care and reduce the potential for primary care to help develop “bridging” social capital in a fragmented society.

⁴⁵ Health Care Commission Patient Survey 2005 www.healthcarecommission.org.uk

⁴⁶ Vide: Baker R, Boulton M, Windridge K, Tarrant C, Bankart J, Freeman G. Interpersonal continuity of care: a cross-sectional survey of primary care patients’ preferences and their experiences. *BJGP*. Vol 57, Number 537, April 2007, pp. 283–9(7).—Schers H, van den Hoogen H, Bor H, Grol R, van den Bosch W (2005). Familiarity with a GP and patients’ evaluations of care. A cross-sectional study. *Fam Pract* 2005;22: 15–9. -Health Inequalities Standing Group of the RCGP. *Hard Lives. Improving the Health of People with Multiple Problems*. Royal College of General Practitioners, London.

⁴⁷ In author’s practice area, www.jigginslane.org.uk, patients can choose between 3 to 5 Doctors’ surgeries, all of which are open to new patients.

⁴⁸ Putnam RD (2000) *Bowling Alone*. The collapse and revival of American community New York, Simon and Schuster

⁴⁹ With the possible exception of schools, there are no other institutions that offer low threshold access to personal care to everyone, including the socially marginalised, excluded, isolated, and those that feel different or discriminated on ethnic or religious grounds.

⁵⁰ LeGrand J. *The Blair Legacy? Choice and Competition in Public Services*. Transcript of Public Lecture, London School of Economics 21st February 2006.

⁵¹ Sennett R. *Respect in a world of inequality*. Norton & Comp London 2003.

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- Although education and socio-economic policies are probably more important to help redress societal and health inequalities, the NHS has an essential part to play.
 - Judicious use of for-profit privatisation may not be possible, as runaway for-profit privatisation may ensue.
 - Norway, Sweden and other Nordic Countries have successful, dynamic, equity oriented and high quality health systems with limited use of the private sector. Lessons could, and should be learned from those countries before further privatisation in the UK is considered.
 - The NHS has made enormous progress in terms of quality improvement, transparency and accountability, thus providing data that can help redress inequalities. This progress may be reversed in case of for-profit commercialisation.
 - Regulatory systems need drastic change and strengthening if they are to be effective in investigating and correcting negative effects of privatisation on quality and equality.
 - The NHS still has superior structures and expertise to help address inequalities in health. The NHS could restart programmes for developing health care infrastructure in deprived areas and encouraging health professionals and other staff to work in deprived areas for the long term by offering non-monetary and monetary incentives. Scotland and Wales have largely retained mechanisms that can promote this end.
 - Many GPs and other health care staff may well accept policies that are not based on for-profit privatisation, that maintain and improve accountability and transparency and do more to help redress the inverse care law. Many GPs and others wish to work for very long periods, if not the whole or greater part of their working lives, in the same area, facilitating the development of trusting and long lasting relationships with patients, the development of a sense of ownership, local anchoring, knowledge of local structures and networks. They thus provide a long term basis for programmes and activities that can help reduce health inequalities.

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January 2008

Memorandum by Dr Sebastian Kraemer (HI 11)

HEALTH INEQUALITIES IN CHILDREN AND YOUNG PEOPLE⁵³

SUMMARY

- The NHS can only do so much, and usually it's too late
- Most health inequalities are due to social and income inequalities, which have increased to prewar levels since their lowest in the 1970s. This rise is far greater than in other comparable countries, except USA.
- Health promotion efforts, such as advertising, social planning, education, and advice are washed away in the tide of relative disadvantage. The committee needs to understand the key point about inequality which is that it effects the whole population, not just the ones at the bottom.
- early intervention is the best hope, but this must start at the stage of pregnancy. Current provision for an integrated perinatal service is very poor. NICE's guidance on maternal mental health barely mentions infants or fathers, and effectively lets us wait until the woman has broken down, rather than intervening earlier.
- paid maternal leave is associated with lower infant mortality.

⁵² Gilles de Wildt is a Birmingham GP and Honorary Clinical Lecturer (University of Birmingham). Previously, he worked in public health and hospital care in the Netherlands and Southern Africa. He helped develop responses in the field of economic policies and health for Dutch and UK non-governmental organisations and the Health Inequalities Standing Group of the RCGP. He has published and presented on these themes. Competing interest: shareholder of South Docs Ltd, a GP led organisation that is interested in delivering health services in and around Birmingham.

⁵³ But there are of course effects at all ages see. Gary W. Evans, Elaine Wethington, Meredith Coleman, Margo Worms, and Edward A. Frongillo, Income Health Inequalities Among Older Persons: The Mediating Role of Multiple Risk Exposures *Journal of Aging and Health* 2007, doi:10.1177/0898264307309938 email: gwe1@cornell.edu.

EVIDENCE

1. *Wealth inequality undermines well meant interventions*

1.1 Between 1980 and 2000 the UK moved from being one of the most equal to one of the most unequal states in EU⁵⁴. High average incomes are irrelevant in such a society. Unlike poverty⁵⁵, which is exclusion through lack of money, inequality affects most of the population by increasing insecurity and anxiety and decreasing trust and self esteem across the board⁵⁶.

1.2 Inequality corrodes social cohesion and aggravates pre-existing psychological vulnerabilities⁵⁷ and is associated with higher rates of educational failure⁵⁸, teenage pregnancy⁵⁹, adolescent self harm⁶⁰, substance abuse, violence⁶¹, obesity⁶², imprisonment, chronic stress and mistrust as well as steep variations in child mortality⁶³.

1.3 A recent study showing increases in adolescent conduct problems in UK⁶⁴ failed to notice the correlation between this and the massive rise in national income inequality over the same period. A contrasting finding in the Netherlands⁶⁵ showed little change in adolescent problems over this period. Income inequality had not changed significantly there, either⁶⁶.

1.4 Most of the beneficial effects of—for example—better nutrition and interventions to reduce obesity⁶⁷ and teenage pregnancy⁶⁸ safer and more attractive places to play⁶⁹, greater access and facilities for music⁷⁰, art, sport and drama, policies and practices to diminish educational disadvantage⁷¹, safer and healthier

⁵⁴ http://en.wikipedia.org/wiki/Gini_coefficient&Correlation_with_per-capita_GDP provides a graphic account of this.

⁵⁵ “under present policies. . . . the poverty rate would be fairly stable, and fall substantially short of meeting government targets for reduction”. Brewer M, Browne J, Sutherland H. (2006) *Micro-simulating child poverty in 2010 and 2020*. IFS. http://www.ifs.org.uk/publications.php?publication_id=3656

⁵⁶ Wilkinson R (2005) *The Impact of inequality*. Routledge. Wilkinson R, Pickett K (2006) Income inequality and population health: A review and explanation of the evidence *Social Science & Medicine* 62 (7) 1768–1784.

⁵⁷ “..what really matters about income is where you are in relation to others in your society, ie it is a matter of relative income or social status, not whether the population in one rich country is on average twice as rich as that of another . . . There is little doubt that insecurities we may carry with us from a difficult early childhood can be exacerbated by the insecurities of low social status. Neither helps confidence or make you feel valued.” The Impact of Inequality; the empirical evidence. Wilkinson R. (2006) *Renewal* 14(1), 20–26.

⁵⁸ Teese R, Lamb S, Duru-Bellat M (eds) (2006) *Education and Equity: International Perspectives on Theory and Policy*. Springer/Kluwer.

⁵⁹ Crosby RA, Holtgrave DR (2006) The protective value of social capital against teen pregnancy: a state-level analysis *Journal of Adolescent Health* 38; 556–559.

⁶⁰ Gunnell D, Shepherd M, Evans M. (2000) Are recent increases in deliberate self-harm associated with changes in socio-economic conditions? An ecological analysis of patterns of deliberate self-harm in Bristol 1972–3 and 1995–6. *Psychological Medicine*, 30: 1197–1203.

⁶¹ Fajnzylber P, Lederman D, Loayza N. (2002) Inequality and Violent Crime *The Journal of Law and Economics* 45; 1–39.

⁶² Armstrong J, Dorosty AR, Reilly JJ, Emmett P (2003) Coexistence of social inequalities in undernutrition and obesity in preschool children: population based cross sectional study. *Arch Dis Child*. 88; 671–5. it is not surprising that physical activity alone is not sufficient to prevent obesity, even in preschool children <http://www.bmj.com/cgi/content/full/333/7577/1041>

⁶³ Platt M.J (1998) Child health statistics review, 1998 *Arch Dis Child* 79, 523–527. Petrou S, Kupek E, Hockley C, Goldacre M. (2006) Social class inequalities in childhood mortality and morbidity in an English population *Paediatric and Perinatal Epidemiology*, 20, 14–23.

⁶⁴ Collishaw S, Maughan B, Goodman R, & Pickles A (2004) Time trends in adolescent mental health. *Journal of Child Psychology and Psychiatry* 45, 1350 “an increase in non-aggressive conduct problems such as lying, stealing and disobedience rather than aggressive problems such as fighting” *Time trends in adolescent well-being*. The Nuffield Foundation 2004 Seminars On Children And Families: Evidence And Implications. A possible correlation between adolescents and political/business leaders who are also not honest cannot be ignored.

⁶⁵ Verhulst, F.C., van der Ende, J., & Rietbergen, A. (1997). Ten-year time trends of psychopathology in Dutch children and adolescents: No evidence for strong trends. *Acta Psychiatrica Scandinavica*, 96, 7–13.

⁶⁶ Weeks J. (2005) *Inequality Trends in Some Developed OECD Countries* DESA Working Paper No. 6 www.un.org/esa/desa/papers/2005/wp6_2005.pdf

⁶⁷ eg Gortmaker SL, Peterson K, Wiecha J, Sobol AM, Dixit S, Fox MK, Laird N. (1999) Reducing Obesity via a School-Based Interdisciplinary Intervention Among Youth: Planet Health. *Arch Pediatr Adolesc Med*, 153: 409–418. <http://archpedi.ama-assn.org/cgi/content/abstract/153/4/409>.

⁶⁸ see *Reaching out: an action plan on social exclusion* (p65–6). This is an impressive document but its technocratic terms of reference do not permit recommendations that would reduce inequalities nationally http://www.cabinetoffice.gov.uk/social_exclusion_task_force/

⁶⁹ children and adults do not always want to be together, so requiring supervision for outdoor play can become a persecutory activity for both parties. *Neighbourhood play and community action* is an innovative project using local groups. See www.jrf.org.uk, and also <http://www.demos.co.uk/projects/childrenmakeplaces/bookmarks/>

⁷⁰ <http://education.guardian.co.uk/artsschools/story/0,,1929204,00.html>

⁷¹ eg the inspiring work of Dr Tony Sewell with black boys www.generatinggenius.com

routes to school, robust anti-bullying policies^{72, 73}, better resources for children with special needs and for looked after children, a less oppressive school testing regime, a more comprehensive curriculum, more enlightened and regulated media (tv, radio, internet, advertising⁷⁴) etc. will simply leak away in the gap between the haves and the have-nots⁷⁵. Social incohesion undermines family and school life, and health.

2. Early years interventions that can reduce risk to children

2.1 Perinatal: From conception onwards the resilience of children is compromised by stress and insecurity in their parents^{76, 77}. Both anxiety during pregnancy⁷⁸ and depression after it⁷⁹ have serious effects on the health and development of the child. The most socially deprived mothers are far more likely to have very premature births⁸⁰. Despite recommendations from the National Service Frameworks (NSF)⁸¹, there is a woeful lack of services (and poor coordination of what exists) for mothers and fathers between conception and the time of birth. This misses the only opportunity for true early intervention with those most at risk⁸².

2.2 Paid parental leave: Fully funded maternal leave is associated with lower child mortality ("a ten week extension in paid leave is predicted to decrease post neonatal mortality rates by 4.1%"⁸³). This remarkable finding should have an immediate impact on policy, and not only to save lives. Death is merely the tip of an iceberg of physical, mental and developmental disorder. (And in the upbringing of infant boys it is useful to know that, despite appearances, they are more vulnerable and immature than girls.⁸⁴) Fathers have to be involved from the beginning and are more likely to do so, and to play an equal role in parenting, if their leave is adequately paid for⁸⁵. Even if he later separates from the mother, a father's devotion to his children is stronger if he has got to know the baby intimately from birth.

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⁷² Twemlow SW, Fonagy P, Sacco FC, Gies ML, Evans R, Ewbank R. (2001) Creating a peaceful school learning environment: a controlled study of an elementary school intervention to reduce violence. *Am J Psychiatry* 158, 808–10.

<http://ajp.psychiatryonline.org/cgi/content/abstract/158/5/808>

⁷³ and children are not the only victims. "Sexist bullies 'target teachers'" <http://news.bbc.co.uk/1/hi/education/6177470.stm>

⁷⁴ Which (2006) *The Food Fables Report*.

http://www.which.co.uk/reports_and_campaigns/food_and_drink/campaigns/kids_food/Food%20Fables%20report/Food_fables_campaign_560_100488.jsp

Compass (2006) *Commercialisation of childhood*

<http://www.compassonline.org.uk/campaigns.asp>

⁷⁵ "We've forgotten to teach social skills, and our children are stagnating"

<http://www.guardian.co.uk/commentisfree/story/0,,1941915,00.html>

⁷⁶ Field T, Hernandez-Reif M, Diego M, Figueiredo B, Schanberg S, Kuhn C. (2006) Prenatal cortisol, prematurity and low birthweight, *Infant Behavior and Development*. 29, 268–275 and Gutteling B, de Weert C, Willemsen-Swinkels S, Huizink A, Mulder E, Visser G, Buitelaar J (2005) The effects of prenatal stress on temperament and problem behavior of 27-month-old toddlers. *Eur Child Adolesc Psychiatry* 14, 41–51

<http://springerlink.metapress.com/content/1552610k7012/?p=f45fed416ce24220ad77152820ffd8bf&pi=13>

⁷⁷ Though the data is from another country (one with a higher standard of living than ours), rates of preterm births may be increasing; Langhoff-Ross J, Kesmodel U, Jacobsson B, Rasmussen S, Vogel I. (2006) Spontaneous preterm delivery in primiparous women at low risk in Denmark: population based study. *BMJ* 332:937–939

http://www.bmj.com/cgi/content/abstract/332/7547/937?ikey=0706cf467a10e5008f30e83c84f29cabf9a4e62e&keytype2=tf_ipsecsha

⁷⁸ O'Connor T, Ben-Shlomo Y, Heron J, Golding J, Adams D, Glover V. (2005) Prenatal Anxiety Predicts Individual Differences in Cortisol in Pre-Adolescent Children. *Biological Psychiatry* 58, 211–217.

⁷⁹ Cooper PJ, Murray L. (1998) Postnatal depression. *British Medical Journal* 316, 1884–6.

<http://bmj.bmjournals.com/cgi/content/extract/316/7148/1884>

⁸⁰ Smith LK, Draper ES, Manktelow BN, Dorling JS, Field DJ (2007) Socioeconomic inequalities in very preterm birth rates. *Archives of Disease in Childhood—Fetal and Neonatal Edition*, 92, F11–F14.

⁸¹ 40492/Child and Adolescent Mental Health—National Service Framework for Children, Young People and Maternity Services, 2004, section 3, standards 2, 9. 29433/Women's Mental Health, *Into the Mainstream. (s12) DoH 2002, section 12* 40498/Maternity—National Service Framework for Children, Young People and Maternity Services, 2004 sections 5, 7, 9.

⁸² The creation of comprehensive perinatal services requires vision and leadership from several national organisations, representing midwives, obstetricians, health visitors, general practice, health psychology, psychiatry (both child and adult), psychotherapies, social services, sure start and voluntary agencies. There is very little evidence of this so far. see also Currid T (2004) Improving perinatal mental health care. *Nursing Standard*. 19 (3) 40–43.

⁸³ Tanaka S (2005) Parental Leave and child health across OECD countries *The Economic Journal* 115, F7–F27.

⁸⁴ Kraemer S. (2000) The fragile male *British Medical Journal* 321, 1609–1612

<http://bmj.bmjournals.com/cgi/content/full/321/7276/1609>

⁸⁵ O'Brien M (2005) *Shared caring: bringing fathers into the frame*, EOC www.eoc.org.uk/Default.aspx?page=16052F see also www.fathersdirect.com

Memorandum by Public Management Associates (PMA) (HI 12)

THE CONTRIBUTION OF THE NHS TO REDUCING HEALTH INEQUALITIES

INTRODUCTION

1. PMA is a independent research and consultancy organisation which hosts the Tobacco Control Collaborating Centre, set up by the Health Development Agency in 2004.

2. Together with a wide range of work in the general field of Public Health PMA has undertaken a series of Health Inequality Audits for health partnerships between the NHS and Local Authorities in the Midlands, the North West and North East of England.

3. We have developed both an extensive evidence base of interventions which directly impact upon and reduce the experience of health inequalities as well as developing a methodology which examines, at the level of a local government ward, the main “drivers” of health inequality as measured by reduced longevity and infant mortality in those specific locations.

4. From such an analysis and with an understanding of the correlations across a range of domains, examining over a hundred variables, we are able to develop a “prescription” for action—again ward by ward—which can be used to inform public policy in both a Local Authority and a Primary Care Trust.

EXECUTIVE SUMMARY

5. In addition to this summary note we can supply an example of such a study designed on this occasion for Birmingham Health and Well Being Partnership, this is not intended to be read as a report—hence it includes a CD. Similar reports exist for other health economies and all of them exhibit the following characteristics:

- The position of an authority with reference to the health domain variables is by no means the most significant determinant of life expectancy or indeed other forms of mortality and morbidity.
- The most significant correlations with life expectancy and infant mortality are educational achievement and level of income.
- Most effective interventions by public bodies designed to reduce health inequalities are likely to be in the sphere of Local Government rather than the NHS.
- There is a well established evidence base of public service interventions which can be demonstrated to reduce the incidence of poor health and early mortality.
- The pattern of health inequality appears to be driven by different variables in different locations and such locations vary significantly within Local Authorities boundaries not simply between Local Authorities.
- Effective interventions to reduce health inequalities need to be more finely tuned to the characteristics of local areas rather than simply targeting whole health economies or Local Authorities allows.
- There is a tendency to sustain Julian Tudor-Hart’s inverse care law when initiatives to address health inequalities are undertaken. The areas requiring least intervention tend to be those receiving most and vice versa.

THE ROLES OF THE NHS AND LOCAL GOVERNMENT

6. Our work in this area demonstrates that effective interventions to address health inequalities will require most action by Local Authorities rather than the NHS. This is no surprise. The Right Hon. Tessa Jowell when Minister of State for Public Health observed that the NHS pulls people out of the river but the task is to go upstream and prevent individuals falling in.

7. The dilemma for Local Authorities is that because of the split in functions between health and other social policy interventions—their focus rarely takes into immediate account the distribution of well being and general life chances. This is ironic in view of the role Local Authorities have played in urban development, economic regeneration and neighbourhood renewal. As Graham Watts, Professor of General Practice in the University of Glasgow, has observed “dying before your time is the ultimate social exclusion”.

8. We do believe that it is possible for a genuine partnership to emerge between the NHS and their Local Authority partners which allows the NHS to maintain its role as “critical friend”. Auditing the epidemiological profile of a community and undertaking the analysis that will be required to determine effective interventions at the most local level is perhaps the most valuable role the NHS can play.

9. It is clear from work we have done with Local Authorities and Primary Care Trusts that such Health and Well Being Partnership were able to do just this. As a result they have been able to ensure that Local Authority, NHS and Social Security staff, together with colleagues in policing and the voluntary section can

develop a sophisticated understanding of the drivers of health and well being in a particular ward of the city, develop local budgets which reflect these priorities and implement evidence based policies, shown to effectively diminish the incidence of disadvantage between resident communities.

10. Another important aspect of addressing inequalities is to ensure that funds intended for this purpose actually target the areas of need. In our work we have identified plenty of evidence that the process of bidding for funds and performance managing inequalities projects are not sufficiently robust eg bid submissions refer to “priority areas” without defining how these priorities have been measured or identified and performance outcomes are frequently reported at an aggregate level without demonstrating that they have reached the intended target.

CONCLUSIONS

11. The pattern of health and social deprivation that exists in the UK is understood by its citizens only too well. The Public Health White Paper “Choosing Health” demonstrates that “76% of people in the higher income groups expect to be in good health in ten years time compared to 53% in the lowest groups” (Cmnd 6374, page 10).

12. Just as the Government recognises that “Spearhead Authorities” have specific needs that require additional priority and attention, so within these local authorities we can identify different areas of need not merely between the affluent and the deprived but within such groupings we find different “drivers” creating need and underpinning it. We have created a means of differentiating not only need but the causes of such need. Whilst it is the case that simple correlation between a particular domain such as crime, education or income and poor life expectancy or early mortality does not “prove” a cause or link nonetheless we have available to us in an evidence base clear demonstrations that many of the domains identified in this work do indeed “drive” poor health outcomes in both morbidity and mortality. As a result we can see why centrally imposed initiatives including Education Action Zones, Health Action Zones, SureStart, New Deal for Communities, Neighbourhood Renewal Schemes—the list is almost endless—coming as they do out of Central Government cannot hope to locate, precisely, the variety of factors which shape the experience of deprivation in small localities. It is because of this fact that such Strategic Partnerships have been tasked with the development and the integration of more locally determined interventions’.

13. For each ward we have researched we have been able to identify sets of interventions which directly relate to the factors which most appear to correlate with the health outcomes we wish to address. Each ward therefore has a strategic set of interventions which address those factors correlating most clearly with healthcare need as defined by the floor targets. For the Local Authority as a whole then a health inequality strategic programme designed to achieve its targets over the next five years will comprise different priorities in different wards and the identification of these priorities forms the heart of this report’. This then becomes—in effect—a sophisticated and finely “textured” Joint Strategic Needs Assessment.

14. The approach described here is conceptually simple though organisationally complex. It does require a significant amount of hard analytical work. It is necessary to ensure that all the partners in the enterprise understand the methodology being used and its purpose and the importance of differentiating effective evidence based practice in areas which exhibit different patterns of need. Furthermore, it goes to the heart of the matter: the NHS primarily “counts them in and counts them out” that is, the birth and death rates are understood, readily available and capable of significant analysis. However, what happens to individuals between their birth and death is primarily determined not by the NHS but by those environmental factors that are most susceptible to the interventions of other public bodies—primarily those involved in Local Government, income maintenance and policing. Ensuring that those factors are kept in mind by those crucially importance agencies is the job of the NHS but delivery of the interventions remains the task of its partners.

*Professor Bryan Stoten
David Wigley*

January 2008

Memorandum by fpa (HI 13)

HEALTH INEQUALITIES

EXECUTIVE SUMMARY

1. fpa is the UK’s leading sexual health charity working to enable people in the UK to make informed choices about sex and to enjoy their sexual health free from exploitation, oppression or physical or emotional harm.

2. Sexual ill health is not equally distributed amongst the population. This was recognised by the Government in the National Strategy on Sexual Health and HIV.

3. Teenage pregnancy is both a cause and a consequence of inequalities. Research has shown that teenage parents and their children experience lower social, economic and health outcomes than their peers.

4. Although teenage pregnancy is a complex issue affected by a variety of factors, an analysis of the links between deprivation and teenage conceptions showed that the most deprived 20 per cent of local authorities in England had a teenage conception rate twice that of the least deprived 20 per cent.

5. The national average of conceptions ending in abortion is 22.6 per cent in England. This percentage varies widely throughout the country. Although there will be a variety of reasons for this variation, the availability of contraceptive services will play an important role.

6. It is vital that women are able the access to full range of methods of contraception to enable them to choose the one that is most suitable for them and to help them avoid unintended pregnancies. The NHS must ensure that these services are available throughout the country and that all women can access them.

7. Data show disproportionate rates of STIs, including HIV, amongst people from some black and minority ethnic groups, young people and men who have sex with men.

8. Sexual health services can play a vital role in improving people's sexual health and reducing the transmission of infections. Although improvements have been made in the number of people able to access an appointment at a GUM clinic, there is concern that some people still find it difficult to access appointments.

1. INTRODUCTION

1.1 Sexual ill health is not equally distributed amongst the population. It disproportionately affects certain groups, often those who are already experiencing high levels of social exclusion and health inequalities. This was recognised by the Government in the National Strategy on Sexual Health and HIV in 2001⁸⁶.

1.2 The highest levels of sexual ill health are experienced by women; men who have sex with men; young people, particularly those who are in or leaving care; and people from black and minority ethnic backgrounds.

1.3 In some areas there may also be individuals or groups who face specific obstacles to accessing information or mainstream services and are therefore at higher risk of sexual ill health. This can include: refugees and asylum seekers; people who are homeless; sex workers; people in custodial settings; and people with physical impairments or learning difficulties.

1.4 It is vital that sexual health service providers take action to identify and respond to the specific needs of their local populations. This includes addressing issues such as the provision of information, the advertising of services and accessibility.

1.5 Rates of sexual ill health remain persistently high amongst the groups identified in the National Strategy for Sexual Health and HIV, which suggests that progress is still not being made in meeting the specific needs of these people.

2. TEENAGE CONCEPTIONS

2.1 Rates of under 18 conceptions in the UK are the highest in Western Europe. Research has shown that rates of teenage conceptions are associated with levels of deprivation.

2.2 Teenage pregnancy is both a cause and a consequence of inequalities. Research has shown that teenage parents and their children experience lower social, economic and health outcomes than their peers.

2.3 Although teenage pregnancy is a complex issue affected by a variety of factors, an analysis of the links between deprivation and teenage conceptions showed that the most deprived 20 per cent of local authorities in England had a teenage conception rate twice that of the least deprived 20 per cent⁸⁷.

2.4 There are also differences in the outcomes of teenage pregnancies, which are associated with deprivation. The percentage of teenage conceptions that end in abortions tends to be higher in less deprived areas.

2.5 Analysis has shown that the fact that less deprived areas have fewer teenage conceptions and a greater percentage of those conceptions end in abortions means there is approximately a ten fold difference in the number of teenage pregnancies that result in a live birth between the least and the most deprived wards.

2.6 Given that outcomes for teenage parents and for their children are lower than their peers, it is vital that local services identify those young people who are at significant risk of unintended pregnancies. It is also important to ensure that young people at risk are able to access objective evidence-guided information about contraception and pregnancy choices, and services to provide them with support.

⁸⁶ Department of Health, *Better Prevention, Better Services, Better Sexual Health: The National Strategy for Sexual Health and HIV* (London: DH, 2001).

⁸⁷ Uren Z, Sheers D and Dattani N, "Teenage conceptions by small area deprivation in England and Wales", *Health Statistics Quarterly*, No 33, Spring (2007) 34–39.

2.7 Data has shown that some areas are making significant progress in reducing their rates of under-18 conceptions⁸⁸. Analysis by the Teenage Pregnancy Unit⁸⁹ has shown that partnerships working and strong leadership at a local level are key characteristics of areas that have made progress. The NHS has a vital role to play in supporting this activity at a local level.

3. UNINTENDED PREGNANCIES

3.1 In 2005, the percentage of conceptions ending in abortion in England was 22.4 per cent⁹⁰. However, this percentage varied widely throughout the country, from 16.3 per cent to 38.1 per cent. Although there will be a variety of reasons for this variation, the availability of contraceptive services will play an important role.

3.2 Access to contraceptive services is vital to reducing unintended pregnancies. However, the Department of Health's baseline audit of contraceptive services⁹¹ showed that 70 per cent of the PCTs who responded had not completed an audit of contraceptive prescribing in community contraceptive clinics. Only five per cent of PCTs who responded had undertaken a comprehensive audit of the use of long-acting reversible methods of contraception (LARC) and 20 per cent of PCTs had policies in place to restrict the use of LARC.

3.3 Since the Department of Health published the audit, fpa has been aware of a number of closures of community contraception clinics, which will have a significant impact on women's access to the full range of contraception, not least because of the role community contraceptive clinics play in providing training for other healthcare professionals in contraception.

3.4 Community contraceptive clinics are particularly important for vulnerable women, such as refugees and asylum seekers, sex workers and young women who may find it difficult to access contraception through other services. For example, obstacles to accessing contraception through general practice can include concerns about confidentiality, particularly in rural areas, or opening times, which do not allow appointments outside school, college or work hours.

3.5 It is vital that women are able to access the full range of methods of contraception to enable them to choose the one that is most suitable for them and to help them avoid unintended pregnancies. The NHS must ensure that these services are available throughout the country and that all women can access them. The current variations in rates of unintended pregnancies suggest that this is not currently the case.

4. SEXUALLY TRANSMITTED INFECTIONS

4.1 Data show disproportionate rates of STIs, including HIV, amongst people from some black and minority ethnic groups, young people and men who have sex with men.

4.2 The National Chlamydia Screening Programme Annual Report 2005–06⁹² included data that showed that positivity was highest in black ethnic groups and lowest in Chinese and Asian populations. Overall approximately 10 per cent of tests were positive. However, this rose to 14 per cent of tests in black British and black Caribbean populations. In contrast, around 5 per cent of tests were positive amongst people from the Asian subcontinent.

4.3 In some areas, the National Chlamydia Screening programme has made significant improvements in reaching out to people who often find it difficult to access mainstream services. For example the use of postal kits and venues such as pharmacies have enabled some young people to avoid the stigma and embarrassment that they associate with accessing sexual health services.

4.4 The NHS could have an impact on sexual health inequalities by using more innovative means to deliver sexual health services and taking interventions to people who need them. There are a variety of reasons why people do not or cannot access services and initiatives such as the National Chlamydia Screening Programme can play an important part in overcoming these.

4.5 Rates of new diagnoses of other STIs remain high amongst young people. Data from the Health Protection Agency released in July 2007⁹³ showed that rates of diagnoses of gonorrhoea were highest in young women aged 16–19 and young men aged 20–24. A third of gonorrhoea infections in men were in men who have sex with men. Similarly nearly 60 per cent of diagnoses of syphilis in men were in men who have sex with men.

4.6 Although increases in the number of people coming forward for testing would account for some of the continued increases in sexually transmitted infections, people are still engaging in high risk behaviours and there is no suggestion that the underlying rates of transmission of STIs is decreasing.

⁸⁸ Office for National Statistics, *Teenage Conception Statistics for England 2005* (London: ONS, 2007).

⁸⁹ Teenage Pregnancy Unit, *Teenage Pregnancy: Accelerating the Strategy to 2010* (London: DfES, 2006).

⁹⁰ Office for National Statistics, *Conception Statistics: Conceptions for women resident in England and Wales 2005* (Newport: ONS, 2007).

⁹¹ Department of Health, *Findings of Baseline Audit of Contraceptive Services* (London: DH, 2007).

⁹² National Chlamydia Screening Steering Group, *New Frontiers: Annual Report of the National Chlamydia Screening Programme in England 2005–06* (London: HPA, November 2006).

⁹³ Health Protection Agency, *Annual STIs data, 2006* <http://www.hpa.org.uk/> Accessed 10 December 2007.

4.7 People who suspect they have an STI do not necessarily stop having unprotected sex if they cannot access sexual health services. Therefore, it is vital that sexual health services assess the needs of their local populations and provide adequate services to reduce onward transmission of STIs, particularly for people who engage in high risk behaviours.

4.8 Sexual health services can play a vital role not only in treating infections but also in secondary prevention activities, such as partner notification activities. The Health Protection Agency's Annual Report⁹⁴ noted that prevention activities in GUM clinics had helped to "interrupt" heterosexual transmission of gonorrhoea. However the same was not the case for transmission in men who have sex with men. Consequently, greater effort needs to be put into targeted prevention activities for this group.

4.9 The NHS plays a vital role in tackling sexual health inequalities by ensuring that people are able to access sexual health information and services. In some cases this may involve delivering services in a more innovative way or closer to where people are. Greater capacity within sexual health services and more provision in the community would help to achieve this.

fpa (Family Planning Association)

January 2008

Memorandum by the Nuffield Council on Bioethics (HI 14)

HEALTH INEQUALITIES

Referring to the term of reference:

- The extent to which the NHS can contribute to reducing health inequalities, given that many of the causes of inequalities relate to other policy areas eg taxation, employment, housing, education and local government;
- The effectiveness of public health services at reducing inequalities by targeting key causes such as smoking and obesity, including whether some public health interventions may lead to increases in health inequalities; and which interventions are most cost-effective.

EXECUTIVE SUMMARY

1. In November 2007, the Nuffield Council on Bioethics published a report on *Public health: ethical issues*. In the Report the Council concluded that the reduction of health inequalities must be one of the principal aims of NHS public health policy, and we include the aim of reducing health inequalities as one of the elements of the "stewardship model" for public health that we present in the report. In addition, we comment on different types of inequality, different groups between which inequalities may exist and different ways of reducing them, emphasizing the importance of "prioritarian" strategies that aim to improve health opportunities and outcomes in the most disadvantaged groups. We also note the potential for health policies to increase rather than decrease health inequalities, particularly in the case of information-based schemes. We consider that it is important therefore, to assess the implications of particular public health measures at the planning stage, and to monitor initiatives in terms of their effectiveness, in particular in reducing health inequalities.

2. Two relevant extracts from *Public health: ethical issues* (paras 2.22–2.40 and 3.22–3.34) can be found at Annexes A and B, respectively. Copies can be obtained from the Council or on its website.⁹⁵ The topic of health inequalities does, however, recur throughout the report, and the Health Committee may be interested to refer to it more generally in their examination of this issue.

January 2008

Memorandum by the British Thoracic Society (HI 15)

HEALTH INEQUALITIES

⁹⁴ Health Protection Agency, *Testing Times: HIV and Other Sexually Transmitted Infections in the UK, 2007* (London: HPA, 2007).

⁹⁵ See <http://www.nuffieldbioethics.org/go/ourwork/publichealth/introduction>

1. SUMMARY

1.1 This evidence submission highlights the relationship between health inequalities and respiratory disease, showing that social inequality causes a higher proportion of deaths in respiratory disease (44%) than any other disease.

1.2 The paper goes on to make the case for a respiratory lead within the Department of Health to co-ordinate respiratory services, reducing both regional and health inequalities evident across England.

1.3 The following section focuses on smoking, highlighting the British Thoracic Society's support for further preventative measures in this area.

1.4 The paper also highlights the role that stop smoking services can play in reducing health inequalities in this area (the British Thoracic Society supports stop smoking practitioners through the British Association for Stop Smoking Practitioners).

1.5 Smoking is often the cause of Chronic Obstructive Pulmonary Disease (COPD) which is the focus for the next section of the submission. The paper highlights regional inequalities in COPD, the forthcoming National Service Framework, and makes the case for why Asthma should be included in the COPD NSF.

1.6 Finally, the paper seeks to address some of the specific points laid out in the Health Select Committee news release, which announced the inquiry into Health Inequalities.

2. OVERVIEW OF RESPIRATORY DISEASES

2.1 The facts about the burden of respiratory disease in the UK are stark:

- Respiratory disease cost the UK £6.6 billion in 2004—£3.0 billion in NHS care costs, £1.9 billion in mortality costs and £1.7 billion in morbidity costs.
- Respiratory disease now kills one in five people in the UK
- Social inequality causes a higher proportion of deaths in respiratory disease (44%) than any other disease

2.2 The Government has started to make progress towards more effective prevention, care and management of patients with respiratory disease through policies and guidelines such as the National Service Framework (NSF) for cancer, which covers lung cancer. NICE guidelines for Tuberculosis were published in 2006. In addition NICE guidelines for chronic obstructive pulmonary disease (COPD)—an umbrella term for chronic bronchitis and emphysema have been published and the Department of Health are developing an NSF for COPD. However, research shows that overall NHS services for respiratory disease are patchy and inadequate, with many hospitals and communities lacking vital equipment and services.

2.3 What conditions come under the banner of respiratory disease?

There are over 30 respiratory conditions, many of which are not smoking-related. There are a wide variety of other causes ranging from genetic influences to nutritional, environmental and poverty-related factors.

2.4 Respiratory disease includes—lung cancer, COPD (chronic obstructive pulmonary disease—an umbrella term for chronic bronchitis and emphysema), asthma, sleep apnoea, influenza, pneumonia, tuberculosis, asbestosis/occupational lung disease, cystic fibrosis, bronchiolitis/baby lung disease and fibrosing lung disease.

3. THE RELATIONSHIP BETWEEN RESPIRATORY DISEASES AND HEALTH INEQUALITIES

3.1 *Why more people from lower socio-economic groups suffer from respiratory diseases?*

With over 30 respiratory conditions, the picture is varied but there are cross cutting factors which will cause people from lower socio-economic groups to suffer from respiratory diseases. People from class group C2, D and E are more likely to smoke heavily throughout their lives and this can lead to a wide range of respiratory conditions including lung cancer and COPD.

3.2 Research has also shown that individuals in these classes are more likely:

- To live in poorer housing with potentially higher levels of indoor air pollution
- To consume a diet with a low nutritional intake
- Access NHS primary care less frequently than the national average
- To have less understanding of disease areas and symptoms

All these factors are correlated with a number of respiratory conditions.

3.3 The tables below are taken from a report called "The Burden of Lung Disease" compiled by the British Thoracic Society in 2002 and 2006. It is a unique document that for the first time brought together statistics which showed the huge health and economic burden of respiratory disease in the UK. These tables clearly demonstrate the overt relationship between respiratory diseases and health inequalities.

3.4 Key findings from Table 1:

- It is estimated that 44% of all deaths from respiratory disease are associated with social class inequalities, and would have been prevented if all men had the same death rate for respiratory disease as men employed in professional and managerial classes.
- There are three times as many deaths from respiratory diseases that are associated with social inequalities (44%) than there are cancer deaths that are associated with social inequalities (13%)
- Over eight times as many people (3,800) die from respiratory disease as a result of social inequalities than those who die from coronary heart disease as a result of social inequalities (500) per year in England and Wales

Table 1: Estimates of the numbers of deaths and working years lost per year associated with social class inequalities in mortality, selected causes, men aged 20–64, 1991–93, England and Wales

Cause of death	Numbers of deaths	Working years lost	Proportion of deaths associated with social inequalities
Respiratory disease (162, 460–519)	3,800	29,000	44%
Accidents (E800–949)	1,500	41,000	43%
Suicides (E950–959)	1,300	39,000	40%
Stroke (430–438)	900	9,000	32%
Coronary Heart Disease (410–414)	500	41,000	28%
Cancer—excluding lung cancer (140–162, 163–239)	1,700	21,000	13%
All diseases	17,200	240,000	29%

Source: Office for National Statistics (Dever F and Whitehead M) Health Inequalities Decennial supplement 15. TSO. London.

3.5 Key findings from Table 2:

- There are clear social class gradients in respiratory disease mortality. Social class gradients are steeper for respiratory disease mortality than for mortality in general, with deaths from chronic obstructive pulmonary disease and tuberculosis showing the most marked social class differentials.
- Men aged 20–64 employed in unskilled manual occupations are around 14 times more likely to die from chronic obstructive pulmonary disease, and 9 times more likely to die from tuberculosis, than men employed in professional roles.

Table 2: Standard mortality ratios by selected diseases of the respiratory system and social class, men aged 20–64, 1991–93, England and Wales

Social class	All causes	Chronic obstructive pulmonary disease	Bronchitis and emphysema	Asthma	Tuberculosis	Cancer of bronchus trachea and lung	Pneumonia
		(496)	(490–92)	(493)	(10–18, 137)	(162)	(480–486)
I—Professional	66	21	44	51	32	45	58
II—Managerial and technical	72	42	43	55	47	61	69
IIIN—Skilled (non-manual)	100	78	81	90	75	87	106
IIIM—Skilled (manual)	117	131	125	128	94	138	93
IV—Partly skilled	116	146	137	114	141	132	108
V—Unskilled	189	298	268	229	285	206	197
England and Wales	100	100	100	100	100	100	100
Ratio unskilled manual:professional	2.8	14.2	6.1	4.5	8.9	4.6	3.4
Number of deaths	175,847	3,095	1,331	910	252	16,082	2,916

Source: Acheson D (1998) Independent Inquiry into Inequalities in Health Report. TSO. London.

3.6 Recommended policy solution: The appointment of a senior “Lung Policy Lead” within the Department of Health

- (i) We acknowledge that with over 30 lung diseases NHS respiratory services are not an easy area to plan for national policy makers. Yet the current organisation of the Department of Health business units (i.e. mainly dedicated to serving National Service Frameworks) effectively precludes effective audit, planning and delivery of NHS respiratory policy and services.
- (ii) In light of this situation we believe there is crucial need for the appointment of a senior “lung policy lead” within the Department of Health. This post would help to “join up”—and report on—the delivery of exiting policy (i.e. those lung diseases covered under existing NSF—such as lung cancer under the Cancer NSF)—as well as helping audit and plan future policies and services.
- (iii) In summary this position would:
- Provide a single senior point of contact for key organisations in the respiratory community

- Ensure more effective planning and delivery of NHS respiratory services reducing regional disparities and health inequalities
- Provide the Chief Medical Officer and various DH policy/business units with evidence-based advice
- Be responsible for pulling together/undertaking/analysing a national audit of respiratory services
- In the medium—long term, make major cost savings to the NHS by achieving more efficient delivery of care

4. FOCUS ON SMOKING

4.1 *Smoking contribution to health inequalities*

In England and Wales people of lower social class, income or education have a two-fold increased risk of dying earlier. More than half of this increased risk involves differences in smoking-related death risk due to illnesses such as COPD, lung cancer, heart attack and stroke.

4.2 *Preventing / stopping smoking in this population is a priority.*

The British Thoracic Society lends its support to the following initiatives to prevent smoking:

- Price: successive increases in cigarette price, above the level of inflation have a proven effect on reducing smoking.
- Smoke-free policies: continued development of these policies has proven effect and should include schools policies, prisons and mental health institutions.
- Banning all advertising and promotion: there should be a ban on promotion at point of sale. All tobacco products and images should not be visible at the point of sale.
- Banning of brand promotion: all tobacco brands and tobacco smoking should not be allowed to be viewed on film or TV shown before 9pm. An 18 classification should be applied.
- In addition there should be a continuous media campaign to encourage people to stop smoking.
- Strict measures to stop the illicit smuggling of cigarettes.

4.3 *Stop Smoking Services*

People from lower social classes with lower income have the same desire to stop smoking but find it harder to prioritise. This would suggest that the NHS could do more to help them. A effective means to assist people wanting to give up smoking is the NHS Stop Smoking services. The BTS represent many stop smoking practitioners across the UK through the British Association for Stop Smoking Practitioners (BASSP).

4.4 Of the 1.5 million smokers supported by NHS stop smoking services between 2003 and 2006, researchers from the University of Bath's Tobacco Control Research Group and the University of Edinburgh found that smokers from poorer areas were using these services—and successfully quitting—more often than those from more affluent communities. This shows that the NHS stop smoking services are helping to reduce inequalities in health caused by smoking, say researchers from.⁹⁶

4.5 The study, published in the journal *Tobacco Control*, used data from 1.5 million smokers who were treated by NHS stop smoking services in the three-year period between April 2003 and March 2006. It compared data from smokers who accessed services in officially designated disadvantaged areas (called *Spearhead* areas) compared with other parts of England. The study found that although quit rates were slightly lower for smokers from *Spearhead* areas (52.6 per cent at four weeks compared with 57.9 per cent elsewhere) services were treating them in larger numbers than their more affluent neighbours (16.7 per cent of smokers in *Spearhead* areas were treated, compared with 13.4 per cent elsewhere). The overall effect was that a higher proportion of smokers in the more disadvantaged areas were successful in quitting (8.8 per cent) than those in more affluent areas (7.8 per cent).

4.6 However there has been a failure of Healthcare Professionals to fully use NHS Stop Smoking Services. This is due to lack of knowledge and education. All healthcare Professions should therefore have "tobacco and stopping smoking" as part of their core curriculum.

4.7 There should be continued support for the NHS Stop Smoking Services.

4.8 In terms of Harm Reduction the British Thoracic Society supports the following initiatives:

- (i) Within tobacco it is not nicotine but other components that do damage. It is the nicotine that produces the addiction. The wider use of nicotine as replacement therapy would reduce harm.
- (ii) There should therefore be more incentives for pharmaceutical companies to produce medicine grade nicotine.

⁹⁶ Bauld, L, Judge, K and Platt, S (2007) Assessing the impact of smoking cessation services on reducing health inequalities in England: observational study, *Tobacco Control*, 16, 6, 400–404.

- (iii) There should be more incentives for the smoker to use nicotine replacement instead of using tobacco.
- (iv) There should be consideration for the development of a Nicotine Regulatory Authority.

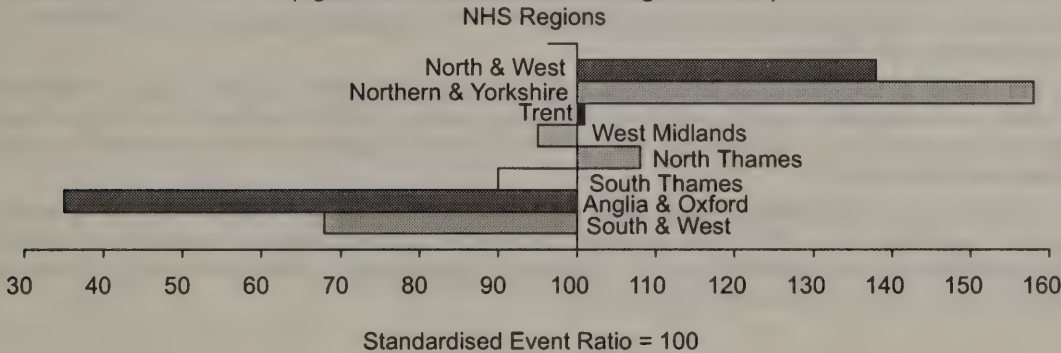
5. REGIONAL INEQUALITIES IN COPD

5.1 COPD is the umbrella term for chronic bronchitis, emphysema and a range of other lung disorders. It is most often due to tobacco smoking.

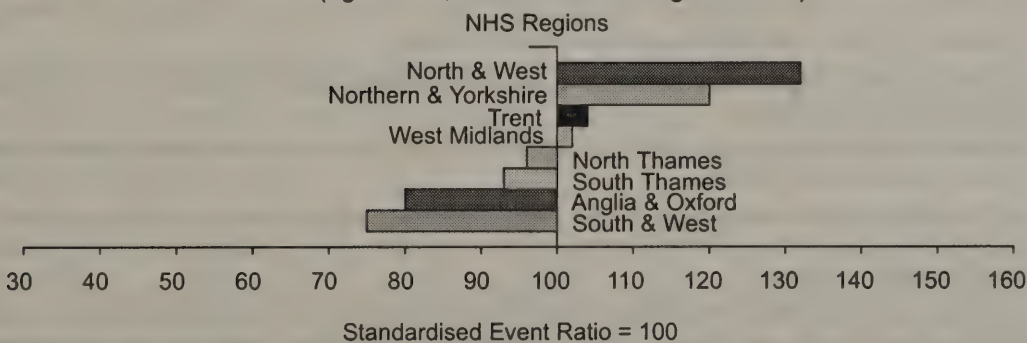
5.2 The diagrams below demonstrate the clear regional disparities in healthcare for COPD.

- Where hospital admissions for Anglia & Oxford are 70% below the national average for COPD, they are almost 60% above the national average in Northern & Yorkshire
- In the North & West region mortality rates are 30% above the national average whereas if you reside in the South & West you have a 30% below average chance of dying from COPD
- Analysis from the General Practice Research Database showed that the number of persons being diagnosed with COPD in primary care were 20% below the national average in the South & West, Anglia & Oxford, South Thames, North Thames and Trent. Compare this to Northern & Yorkshire and North & West where both regions cases of COPD diagnosis in primary care were 50% above the national average.

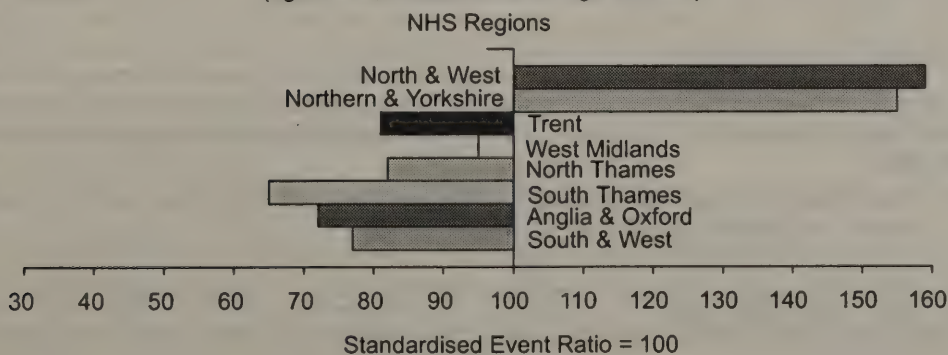
Regional Differences in 1994 for emergency hospital admissions
(ages 0-84, standardised for age and sex)



Regional Differences in 1994 for mortality from COPD
(ages 0-84, standardised for age and sex)



Regional Differences in 1994 for persons in primary care diagnosed with COPD
(ages 0-84, standardised for age and sex)



5.2 The National Service Framework (NSF) for COPD

On 28 June 2006, the Secretary of State announced that a National Service Framework (NSF) should be developed for Chronic Obstructive Pulmonary Disease (COPD) following recommendations published in the CMO's Annual Report 2004.

5.3 Key requirements for the NSF

(i) An integrated approach to respiratory disease across primary and secondary care where care and treatment services are provided in the community deliver measurably benefit patients with COPD, however these are currently patchy across the UK. This means that it should be far easier for patients to gain access to the expertise which they require along their disease pathway. A recent study found that such programmes maintained a significant reduction in hospitalisations after a two-year period. Hospitalisations fell by 26.9% and emergency visits fell by 21.1%⁹⁷

(ii) Results of the second UK COPD audit on Early Discharge Systems (EDS) have shown that about 30% of patients admitted to hospital with acute exacerbations of COPD are suitable for early discharge, meaning a three-day reduction in the length of hospital stay. However, of the 233 hospitals surveyed, only 44% have access to EDS. Furthermore, those hospitals with EDS did not necessarily operate them round the clock.

(iii) Research has shown that pulmonary rehabilitation (a structured programme of exercise and lifestyle advice) is cost effective and results in financial benefits to the health service.⁹⁸ But BTS and British Lung Foundation research estimates that approximately only 1.7% of patients diagnosed with COPD have access to pulmonary rehabilitation

(iv) The BLF Invisible Lives report highlights hot spots for COPD, including types of housing. The findings are unsurprising knowing what we know about causes of COPD, but they've used data to confirm it. Now it needs creative interventions for case-finding and management. The hot spot PCTs should be monitored more closely.

(v) Overall, better funded diagnostic, treatment and care services for COPD—such as spirometry (a crucial breathing test), NIV (non invasive ventilation), Early Discharge Systems and pulmonary rehabilitation—would increase the number of people quitting smoking, improve patient health and reduce hospital admissions and unnecessary treatments

5.4 Asthma: the need to be included in the NSF

The BTS and other stakeholders in the respiratory community believe that it would be logical to extend this NSF to cover other obstructive lung diseases—such as asthma—since they require similar health professional networks and NHS diagnostic/treatment services.

(i) An estimated 75% of hospital admissions for asthma are avoidable and as many as 90% of the deaths from asthma are preventable

(ii) At a local level, the annual cost of managing asthma for an average sized primary care organisation has been estimated at £4 million

(iii) As with COPD—better funded education, diagnostic and treatment programmes for asthma—including a focus on patient self-management of the condition—would help improve patient health and reduce hospital admissions

(iv) In Finland a national 10 year programme for asthma has been set up (1994–5–2004–5)—this has involved central targets, investment in treatment/health professional resource, and regional asthma networks (led by a nominated physician). A core emphasis has been on teaching self-management to patients. Interim research shows that there has been decreased hospital admission rates, decreased time off work for asthma, and increased use of long term preventative drug therapy (inhaled steroids)

6. In response to Specific Questions

6.1 The extent to which the NHS can contribute to reducing health inequalities, given that many of the causes of inequalities relate to other policy areas eg taxation, employment, housing, education and local government;

- (i) As sections 4.3, 4.4 and 4.5 above state, NHS Stop Smoking Services have shown has the NHS can result in a reduction in health inequalities.

⁹⁷ (Gadoury MA, Schwartzman K, Rouleau M, Maltais F, Julien M, Beupre A, Renzi P, Begin R, Nault D, Bourbeau J; Eur Respir J. 2005 Nov;26(5):853–7).

⁹⁸ Griffiths T.L., Phillips C.J., Davies S, Burr M.L., Campbell I.A. (2001) Thorax October 2001, Vol 56, No 10, BMJ Publishing Group, pp. 779–784.

- (ii) Men and women from minority ethnic groups who cannot access services because of language problems, beliefs, or time (wage earners can't get out of work without fear of loss of earnings) require more tailored government attention.
- (iii) For example, the British Thoracic Society is aware of emergencies that sometimes arise when South Asian women, who do not speak much English, wait for their husbands to return from work in the evenings before calling for help for their child or themselves.

6.2 The distribution and quality of GP services and their influence on health inequalities, including how the Quality and Outcomes Framework and Practice-based Commissioning might be used to improve the quality and distribution of GP services to reduce health inequalities;

As section 5.3 above stated an integrated approach to respiratory disease across primary and secondary care where care and treatment services are provided in the community deliver measurably benefit patients with COPD, however these are currently patchy across the UK. This means that it should be far easier for patients to gain access to the expertise which they require along their disease pathway. A recent study found that such programmes maintained a significant reduction in hospitalisations after a two-year period. Hospitalisations fell by 26.9% and emergency visits fell by 21.1%⁹⁹

6.3 Whether specific interventions designed to tackle health inequalities, such as Sure Start and Health Action Zones, have proved effective and cost-effective;

- (i) Sure Start educational services identify parents and children from deprived communities and make an excellent location for screening and advice on children's respiratory problems.

Sheila Edwards
Chief Executive

January 2008

Memorandum by the Infant and Dietetic Foods Association (HI 16)

HEALTH INEQUALITIES

1. EXECUTIVE SUMMARY

1.1 As rates of smoking decline in the developed world, nutrition will become the key risk factor in many diseases.¹⁰⁰

1.2 Studies have demonstrated that poorer socioeconomic status contributes to the risk of the undernutrition¹⁰¹—the effects of which include prolonged hospital stays, delayed recovery, and poor respiratory function.¹⁰² In some studies, undernourished patients have a mortality rate up to eight times higher than that of well-nourished patients.¹⁰³ The total cost of undernutrition to the UK is estimated to be £7.3 billion every year.¹⁰⁴

1.3 Large geographical variations exist in the prevalence of undernutrition in England, with a clear North-South divide.¹⁰⁵ This may explain to some extent the geographical pattern of health inequalities.

1.4 Undernutrition has historically been under-recognised, although there has been an increased focus on the condition in recent years. In particular, the Department of Health's recent *Nutrition Action Plan*—which draws on lessons learnt from earlier work undertaken by the National Patient Safety Agency—should help to tackle the burden of undernutrition in institutional settings, when implemented.

1.5 However, since 2000–01, the number of patients being admitted to hospital in an undernourished state has increased by 67%, suggesting that greater attention needs to be paid towards tackling undernutrition in primary care (in addition to institutional settings). In order to do so, one method which the Committee may wish to consider is the possibility of incorporating indicators of undernutrition in the Quality and Outcomes Framework of the GP contract.

⁹⁹ (Gadoury MA, Schwartzman K, Rouleau M, Maltais F, Julien M, Beaupre A, Renzi P, Begin R, Nault D, Bourbeau J; Eur Respir J. 2005 Nov;26(5):853–7).

¹⁰⁰ *Nutrition*, Diet and eating habits in high and low socioeconomic groups, May 2005.

¹⁰¹ *Nutrition*, Geographical inequalities in nutrient status and risk of malnutrition among English people aged 65 years and older (Marinos Elia MD and Rebecca J. Stratton Ph.D.), 18 March 2005.

¹⁰² National Patient Safety Agency, *Nutritional Screening Structured Investigation Report*, 2 July 2007.

¹⁰³ *Journal of General Internal Medicine*, Protein-energy undernutrition and life-threatening complications among the hospitalised elderly, 2002.

¹⁰⁴ Cited in Department of Health, *Improving nutritional care*, October 2007.

¹⁰⁵ *Nutrition*, Geographical inequalities in nutrient status and risk of malnutrition among English people aged 65 years and older (Marinos Elia MD and Rebecca J. Stratton Ph.D.), 18 March 2005.

2. INTRODUCTION

2.1 The Infant and Dietetic Foods Association (IDFA) is the trade association representing UK manufacturers of specialist nutrition products (infant, clinical, sports and slimming foods)—a category of foods specially formulated for adults and infants with particular nutritional requirements, such as those used in enteral nutrition (nutritional feeds taken by mouth or tube directly into the gastrointestinal tract). Specialist nutrition products are highly regulated by European Union and UK legislation.

2.2. The IDFA welcomes the Committee’s Inquiry into Health Inequalities. The findings and conclusions of the Committee will assist the Department of Health, the NHS, and other Government departments and agencies in delivering the Public Services Agreement targets to tackle health inequalities.

2.3 The IDFA believes that undernutrition is often overlooked as a causal factor in explaining the persistence of health inequalities, and would like to bring evidence in support of this to the Committee’s attention.

3. GENERAL

3.1 Undernutrition is estimated to cost the UK £7.3 billion every year, with over half the cost expended on people over the age of 65.¹⁰⁶

3.2 Up to 14% of people aged over 65 are undernourished, while patients admitted to hospital over the age of 80 have a prevalence of undernutrition five times higher than those under the age of 50.¹⁰⁷

4. CONTRIBUTION TO HEALTH INEQUALITIES

4.1 It is estimated that protein-energy undernutrition contributes 3.5% to the overall burden of disease in the European Union¹⁰⁸, and one academic study has suggested that, “as smoking declines in the modern world, nutrition will become the key risk factor in many diseases”.¹⁰⁹ Evidence suggests that undernourished patients are three times as likely to develop complications during surgery¹¹⁰, and have a mortality rate up to eight times higher than well-nourished patients.¹¹¹

4.2 Variations in nutrient intake between different geographical areas may, therefore, explain to some extent the persisting challenge of health inequalities.

4.3 A 2006 study found that patients at risk of undernutrition tend to be admitted to hospital from areas of greater deprivation, and that undernutrition may be a factor in explaining why people admitted to hospital from deprived areas are more likely to die in hospital. This study found that the prevalence of undernutrition increased significantly with the index of multiple deprivation as a whole, and several of its indices including disability, income and employment.¹¹²

4.4 An earlier 2005 study based on the results of England’s National Diet and Nutrition Survey found stark regional variations in the risk of undernutrition amongst those aged over 65. Some of the results of the study are shown in the table below.¹¹³

Table 1: Distribution of undernutrition risk according to geographical variation

	Low risk	Medium risk	High risk
Northern England (the North, the North-West, Yorkshire and Humberside)	80.6%	9.4%	10.4%
Central England (the East Midlands, West Midlands and East Anglia)	87.7%	6.8%	5.5%
Southern England (London, the South-East, and the South-West)	88.7%	5.5%	5.7%

The study identified a range of dietary and socioeconomic factors which may explain the differences in risk, including:

- Intake of fruit and vegetables being 30% lower in the northern region than in the southern region¹¹⁴

¹⁰⁶ Cited in Department of Health, *Improving nutritional care*, October 2007.
¹⁰⁷ Cited in Department of Health, *Improving nutritional care*, October 2007.
¹⁰⁸ National Institute of Public Health (Stockholm), *Determinants of the burden of disease in the European Union*, 1997.
¹⁰⁹ *Nutrition*, Diet and eating habits in high and low socioeconomic groups, May 2005.
¹¹⁰ Cited in Department of Health, *Improving nutritional care*, October 2007.
¹¹¹ *Journal of General Internal Medicine*, Protein-energy undernutrition and life-threatening complications among the hospitalised elderly, 2002.
¹¹² *British Journal of Nutrition*, Deprivation linked to malnutrition risk and mortality in hospital, 2006.
¹¹³ *Nutrition*, Geographical inequalities in nutrient status and risk of malnutrition among English people aged 65 years and older (Marinos Elia MD and Rebecca J. Stratton Ph.D.), 18 March 2005.
¹¹⁴ *Nutrition*, Geographical inequalities in nutrient status and risk of malnutrition among English people aged 65 years and older (Marinos Elia MD and Rebecca J. Stratton Ph.D.), 18 March 2005.

- People living in the northern region being more likely to live alone and to have fewer natural teeth, which may present difficulties in obtaining access to food and in swallowing respectively.¹¹⁵

4.5 The importance of improved nutrition in tackling health inequalities has long been recognised by the Department of Health:

- Its 2001 consultation on a health inequalities strategy noted that, “communities most at risk of ill-health also tend to experience the least satisfactory access to a full range of preventive services”, and called on “PCTs to act as a focal point for the delivery of public health programmes and services, such as . . . diet and nutrition advice”.¹¹⁶
- Its 2003 document, *Tackling health inequalities: a programme for action*, demanded the improvement of, “diet and nutrition across disadvantaged groups and children by implementing the Food and Health Action Plan across Government and other sectors”.¹¹⁷
- Its 2005 public health strategy, *Choosing a better diet: a food and health action plan strategy*, acknowledged that, “poor nutrition is a major cause of ill health and premature death in England”.¹¹⁸

5. PROGRESS

5.1 In spite of the Department of Health’s welcome focus on nutrition in tackling health inequalities, the burden of undernutrition appears to be increasing. Data drawn from the Hospital Episodes Statistics database show that, in 2000–01, 77,988 patients were admitted to hospital with a diagnosis of a nutritional deficiency, but by 2006–07 this number had increased to 130,594 (an increase of 67%).¹¹⁹

5.2 These figures are likely to significantly under-report the scale of undernutrition: a study conducted in September 2007 by the British Association for Parenteral¹²⁰ and Enteral Nutrition (BAPEN) (and backed by the Department of Health¹²¹) suggests that one in four adults admitted to hospital are at risk of undernutrition.¹²² In 2006–07, this equated to 3.2 million patients.¹²³

6. FURTHER ACTION

6.1 The Department of Health has recently published *Improving Nutritional Care*—a nutrition action plan designed to address nutritional care in hospitals, care homes and the community.¹²⁴

6.2 We welcome the plan and hope for its speedy implementation. Many of the actions contained in the nutrition action plan have already been identified by the National Patient Safety Agency. These include:¹²⁵

- A lack of equipment (and, in particular, of weighing scales and height measures)
- A lack of clarity relating to the screening and assessment of patients who may be at risk of undernutrition
- The fact that nutritional screening is not mandatory in England

6.3 Although the Department of Health’s *Improving Nutritional Care* action plan is welcome, much of its focus appears to be on tackling undernutrition in institutional settings. The IDFA believes that tackling undernutrition may be made more effective by identifying and tackling the condition in primary care.

6.4 Screening patients for undernutrition on initial registration at a GP surgery (and thereafter where there is a clinical concern) is already recommended by the National Institute for Health and Clinical Excellence¹²⁶, and simple tools—such as the nationally-recommended Malnutrition Universal Screening Tool (MUST)¹²⁷—are available to healthcare practitioners to assist them in identifying patients at risk. However, the rising number of patients admitted to hospital with a diagnosis of undernutrition (see paragraph 5.1, above) suggests that this guidance is not being fully implemented.

6.5 In order to provide appropriate incentives for tackling undernutrition in primary care, the IDFA believes there is a case for including indicators of undernutrition in the Quality and Outcomes Framework (QOF) of the General Medical Services contract.

¹¹⁵ *Nutrition*, Geographical inequalities in nutrient status and risk of malnutrition among English people aged 65 years and older (Marinos Elia MD and Rebecca J. Stratton Ph.D.), 18 March 2005.

¹¹⁶ Department of Health, *Tackling health inequalities: consultation on a plan for delivery*, 23 August 2001.

¹¹⁷ Department of Health, *Tackling health inequalities: a programme for action*, 2 July 2003.

¹¹⁸ Department of Health, *Choosing a better diet: a food and health action plan*, 9 March 2005.

¹¹⁹ *Hansard*, 18 December 2007, Col. 1395W.

¹²⁰ Nutritional foods taken by tube directly into the bloodstream.

¹²¹ *Hansard*, 13 December 2007, Col. 883W.

¹²² British Association of Parenteral and Enteral Nutrition, *BAPEN study reveals that 1 in 4 adults across all age groups admitted to hospital and care homes in the UK at risk of malnutrition*, 27 November 2007.

¹²³ There were 12.98 million admissions to NHS hospitals in England in total in 2006–07. Source: Department of Health, *Hospital Episodes Statistics*, 12 December 2007.

¹²⁴ Department of Health, *Improving Nutritional Care*, October 2007.

¹²⁵ National Patient Safety Agency, *Nutritional Screening Structured Investigation Report*, 2 July 2007.

¹²⁶ National Institute for Health and Clinical Excellence, *Nutrition support in adults: NICE guideline*, 20 February 2006.

¹²⁷ *Hansard*, 13 December 2007, Col. 874W.

The Department of Health acknowledges that the QOF, “means that practices are delivering far more preventive work”¹²⁸ and the IDFA is therefore of the view that it is the most appropriate mechanism for encouraging more widespread nutritional screening and nutritional support in the community.

6.6 Improved nutrition is known to reduce instances of cardiovascular disease (including heart disease and stroke), diabetes and some cancers which together are estimated to account for almost 60% of premature deaths in England.¹²⁹

Together these conditions account for 237 points of the 655 QOF points available in the clinical domain, yet none of these points reflect the need for delivering good nutritional care.¹³⁰ In addition, undernutrition has deleterious consequences on a range of other physical and psychosocial conditions¹³¹—such as depression—which are also prioritised in the QOF but for which there is no focus on undernutrition.

We would ask the Committee to consider whether there is a case for reassigning some of these points in order to deliver improved nutrition.

7. CLOSING REMARKS

7.1 The IDFA looks forward to reading the Committee’s report and its recommendations.

7.2 We would be happy to submit further evidence if the Committee would find this helpful.

Roger Clarke
Director-General

January 2008

Memorandum by Dr Jonathan Orrell (HI 17)

HEALTH INEQUALITIES

1.0 EXECUTIVE SUMMARY.

1.1 The NHS is capable of caring for the victims of Health Inequalities.

Action will not happen by accident, through an unseen hand with corporate colonisation or by isolated tick box initiatives, rather it must happen through deliberate, systematic and rigorous determination to shift resources and action to the deprived.

- A move to outcome measures by Dept of Health with the process measures being determined at local level.
- All health service commissioning plans to include health inequalities assessment
- All health spending to redistributed according to inequality based need at SHA, PCT and practice levels.

1.2 BACKGROUND.

This document is the individual submission of a front line sergeant in the trenches of this campaign, observing the effects of NHS policy for two decades. General Haig sought advice from Military Intelligence whose remote observations reassured the top command that all was going well, and with just a bit more of the same effort a breakthrough would come.

1.3 Similarly every SHA and PCT from their safe and insulated positions behind the lines, out of artillery range, will be able to reassure the committee that all is well and a little more of the same effort will suffice. If the committee is really interested then there are practical actions that can be taken at the active front of the NHS.

¹²⁸ Department of Health, *Departmental Report 2007*, 18 May 2007.

¹²⁹ Department of Health, *Choosing a better diet: a food and health action plan*, 9 March 2005.

¹³⁰ NHS Employers, *Quality and Outcomes Framework guidance*, 2007.

¹³¹ *British Journal of Nutrition*, Deprivation linked to malnutrition risk and mortality in hospital, 2006.

2 *The extent to which the NHS can contribute to reducing inequalities, given that many of the causes of inequities relate to other policy areas; eg taxation, employment, housing, education and local government.*

2.1 It is true that the growing awareness of health inequalities are caused by the increasing divergence of wealth inequalities. The gap between the rich and poor was narrowing through the 60s and 70s but has increased since the late 80s and 90s.

2.2 One fault of medicine has been to use reductionism and divide every part of the human body into secondary care organ specific specialties. Humans however are whole organisms and in primary care one endeavours to combine all physical sensations from any organ, with psychological issues and social interactions.

2.3 In the same way to make progress of Health Inequalities we must move back from the artificial subdivision of policy areas and see the interdependence of the system. We are not dealing with a rigidly separated mechanism where actions at the top give predictable effects, like a railway signal box.

2.4 Instead Health and the other policies all interact with one another in a complex adaptive system. This is a living and dynamic web of positive and negative effects where and action at the centre may result in paradoxical effects at the front line. The 24/48 hour access GP targets making patients unable to book in advance being an example.

2.5 In order to make progress on Obesity for example one should not consider this as a purely Health measure with a Health solution. Individual choices are constrained by the built environment, car dominance, advertisements, energy density changes and Inequalities.

2.6 The Foresight report (Government office for science)
http://www.foresight.gov.uk/Obesity/obesity_final/20.pdf. has some well presented web diagrams that outline the multiple inter related factors that affect obesity. The focus on individual measures and Health Interventions are only a small part of the solution. Action must take place on every front simultaneously to make progress.

2.7 We need action on cycle and pedestrian paths; changes in town planning to encourage walking and co locate work, schools, shops and play. Adverts for junk must stop and healthy food be available in poor neighbourhoods. The use of Orlistat and gastric stapling seem to be the NICE option but they are trivial in terms of overall population effects and will not be effective at addressing inequalities.
<http://www.nice.org.uk/CG043>

2.8 The military analogy is the co-ordinated artillery, dive bombing, tank and troop concentrations of the Blitzkreig compared with the Somme.

3.0 *The distribution and quality of GP services and their influence on health inequalities, including QOF and PBC to improve the quality and distribution of GP services to reduce health inequalities.*

3.1 Tudor Hart's Inverse Care law states that: " The availability of good medical care tends to vary inversely with the need for the population served. This inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced. The market distribution of medical care is a primitive and historically outdated social form, and any return to it would further exaggerate the mal-distribution of medical resources."
<http://www.sochealth.co.uk/history/inversecare.htm>

3.2 A system delivers the results for which it is designed. It is often claimed that a NHS priority is to reduce inequality but this is spin. A wise saying is that by their fruits shall you know them.
<http://www.bmj.com/cgi/content/extract/335/7630/1126>

3.3 The actual front line NHS action is to reward GPs working in affluent areas. The remuneration of GPs is partly capitation based which means doctors in affluent rural locations might see 8 patients in a morning surgery whilst another doctor serving an urban council estate will see 25 patients, who are sicker and are genuinely ill.

3.4 The Quality and Outcomes framework by itself will not deliver health equality. The opposite is true as the quiet surgeries in affluent areas with compliant patients achieve the highest scores and rewards. The practices struggling with poor patients with x2 or x3 the levels of morbidity, multiple languages and high turnover get lower scores despite working far harder.

3.5 An action that could be taken to dramatically address inequalities would be to centrally insist that PCTs enact the National Enhanced Service of the nGMS contract to deprived areas.

3.6 There are NES specifications available for Homelessness, People with Addictions, People with Alcohol problems and Depression. These problems are most severe in areas of poverty and GP practices would be able to make the interconnections between these policies that exist in the same areas and individuals.

3.7 Practice based commissioning fundamentally depends on each practice or locality having an adequate initial budget from which to commission services. Our experience is that a deprived locality is affected by Tudor Hart's law and is given a lower budget than an affluent area.

3.8 Our locality serving a poorer urban population is 1.5 million underfunded compared with its fair share allocation as it moves from historical arrangements. The government guidance is that there should be a minimum of a 1% move to fair shares each year. This means it will take 100 years to get fair funds. Our PCT has generously decided on a 3% shift per annum that means it will now only take 30 years for fair funding for a deprived community.

3.9 An action from the central NHS would therefore be to direct PCTs to ensure that PBC funding is equitably targeted to those who are ill and need more care; the poor.

4.0 The effectiveness of public health services at reducing inequalities by targeting key causes such as smoking and obesity, including whether public health interventions may lead to increases in health inequalities.

4.1 Experience has shown that public health has not necessarily be properly targeted to address inequities. In one county there were five areas of population (see below) but only one had any significant deprivation with predictable high levels of heart disease and illness. However public health monies were divided on a strictly population based formula thus the poor area got just as much as the rich areas. This could be seen as equal treatment but it was not equitable.

4.2 In order to tackle inequities funding must be withdrawn from affluent healthy areas and diverted to poor deprived communities who have measurably doubled rates of coronary heart disease, teen pregnancies and schizophrenia.

5.0 Whether specific interventions designed to tackle inequalities such as Sure Start and Health Action Zones have proved effective.

5.1 Health Inequality interventions suffer from the paradoxical effects of well meaning initiatives in complex adaptive systems that favour the rich and affluent.

5.2 Our experience of Health Action Zones is that the levels of funding were trivial and laughably miniscule compared with the whole local NHS budget. Thus they ticked the performance management box and enabled the authority to report action to the chain of command but without really changing anything. In a previous PCT configuration 50 million pounds was spent with no recognition of the effects of or on deprivation, then 30 thousand pounds was allocated to the Health Action Zone. This is window dressing and gives the superficial impression of action without any real change.

5.3 To shift the metaphor from military to culinary; the recent experience of initiatives is that they are the cherry on the cake. Thus the PCT or SHA spends its tens of millions or hundreds of millions as if health inequalities did not exist, on the basis of crude population or rewards to Hospitals for good behaviour.

5.4 If one really wants to address health inequities then the effort must be like a stick of Blackpool rock. The words go through the whole sweet. Similarly PCTs and SHAs should be obliged to consider the health inequity impact of every single contract and every single service, both new and established.

5.5 Health inequalities have been extensively documented through the Black Report and a decade later The Health Divide. The clear and linear relationship between every significant illness and social class is clear to all with eyes willing to see.

5.5 Real progress will come when every decision on spending is fully informed by its impact on redressing the balance on NHS areas of expenditure.

- Health Visitors work harder in deprived communities yet numbers are based on population, so healthy villages get a super service and the poor are neglected.
- Rates of Schizophrenia are measured at double in a deprived town yet the services are the same as for the prosperous market town where life is easy.
- Drug budgets are crudely based on age, sex and temporary patients which account for only 30% of the observed differences in costs. Deprivation affects levels of most illnesses.

5.7 Many of the illnesses in an area are now tracked through the QOF. Deprived areas have more sick people needing medication. It is possible to make further adjustment to drug budgets so that health inequities are addressed.

5.8 The do nothing option on prescribing means that affluent areas with low demand for drugs can make incentive payments to GPs whilst those doctors serving poor areas are penalised for trying to treat patients to proper standards.

5.9 Drug budgets nationally should have an additional allocation formula to redress deprivation and should be nationally fixed. PCTs can currently ignore local deprivation if the county is generally prosperous.

5.10 As regards Health Action Zones care must be taken to avoid rich areas attracting funds. In our county the first HAZs were in areas of genuine measurable urban deprivation. Later a rural idyll with no measurable deprivation at all misapplied statistics to their locality and stole funds from the poor to give to the rich. Those in charge of the HAZ budgets lacked any public health expertise, being accountants and career managers.

5.11.1 Sure Start schemes similarly run the danger of missing their intended target. Health staff like working in quiet pleasant surroundings and are apt to divert funding for their own ends, rather than those of poorer patients.

<http://www.bmj.com/cgi/content/abstract/332/7556/1476?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=sure+start&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT>

5.11.2 This is an example of unintended consequences to a well meaning central initiative. It is a mistake to specify the means to an end and then apply it nationally. In London Sure Start and Poly clinics may be the correct local response to inequalities. However in areas with good primary care a sure start centre may make inequalities worse, by fragmenting Health Visitors from the primary care GP team and literally disintegrating a functioning set up.

6.0 *The success of NHS organisations at co-ordinating activities with other organisations, for example local authorities, education and housing providers, to tackle inequalities; and what incentives can be provided to ensure these organisations improve care.*

6.1 All organisations in the above sectors can tick the performance management boxes by having some joint meetings and shared documents. These do not mean anything has really changed at the front line.

6.2 In our area all the new housing is in the form of luxury flats and the planning regulations that stipulate a percentage of social housing are circumvented. Any moves to cut obesity by encouraging cycling or walking to school or work are utterly undermined by the decision to spend 78 million on a 4 mile road that does not even bypass the main town. This will increase carbon emissions, global warming and waistlines of the poor, who suffer most from the lack of opportunity.

<http://www.bmj.com/cgi/content/extract/335/7630/1104>

6.3 A central change in the rules for education, planning and housing to ensure that there are many more developments with affordable housing, built with zero carbon standards, energy microgeneration, water harvesting and so on. These should be in school/shop/factory/office/GP/home clusters, where people find it easier to walk or cycle than to depend on the car.

<http://www.bmj.com/cgi/content/extract/336/7634/7>

6.4 On the Health side the NICE guidance on obesity is a case in point. It gives a nod to the environment but the main pathways start with an obese patient and then give medical or surgical solutions.

6.5 We must act in a more cohesive and comprehensive manner at all the many points of influence. The NHS currently does its main job of managing budgets and waiting lists for Hospitals then when all the core work is complete a minor effort is expended to tick the boxes that give the impression that joined up activities were really happening. This is a sham.

7.0 *The effectiveness of the Department of Health in co-ordinating policy with other government departments, in order to meet its public service agreement targets for reducing inequalities.*

7.1 Many of the answers to inequalities will also solve sustainability problems. (Foresight Report). The Sustainable Development Commission has excellent ideas for five major areas that the NHS ought to make progress. These are for buildings, procurement, work patterns and so on. There are isolated examples where individual NHS organisations have made limited progress.

7.2 However most of the NHS is in performance management paralysis and remains incapable of moral thought or independent action. If there are no targets or stars then for most of the NHS there will be no action.

7.3 Another example of the failure of the NHS to interact is the Audit Commission. In our area this body examined the services for Mental Health. They noted to substandard investment in doctors but thought this was all right because the county was generally prosperous and healthy. The Audit Commission made the astonishing and ignorant assertion that “there is no deprivation in Dorset”.¹³²

7.4 This view was obviously made without the slightest examination of public health reports or local authority measures which are very clear that whilst the rural hinterland is very rich and prosperous the urban seaside towns have areas that are amongst the poorest quintile in England, thus qualifying for a Sure Start centre and deprivation payments under the old GP contract. Examine Weymouth to see the gross error of the audit commission.

¹³² Performance Summary Report: Mental Health Benchmarking—Dorset Primary Care Trust, Audit 2007–08, page 9.

Dorset Health Profile Figures 2006							
	England	East Dorset	North Dorset	West Dorset	Christchurch	Purbeck	Weymouth and Portland
Teenage Pregnancy	42.1	24.8	23.7	22.6	29.5	24.1	49.2
GCSE achievement	57.5	57.7	60.3	71.5	61.6	62	50.5
Income deprivation	12.9	5.8	6.5	7.4	8.6	7.2	11.2
Child poverty	21.3	10.3	9.8	11.2	15.8	13	19.2
Violent crime	19.8	5	8	9.1	12.9	10.3	25.8
Adult smokers	26	15.8	20	19.2	19.7	20.2	25.3
Deaths from smoking	234.4	149.4	169.9	178.6	169.2	178.6	205
Early deaths from CHD/stroke	90.5	44.9	57.1	64.4	61.6	56.1	83.3
Mental health	27.4	13.5	15.1	22.7	24	17	36.7
Hospital stay due to alcohol	247.7	125.1	150.5	180.1	182	240.1	259.3
Drug Misuse	9.9	5.5	7.5	5.8	11.4	10.9	12.9

Local Authority categories	Most deprived Quintile				Least deprived Quintile
	1	2	3	4	5
Weymouth and Portland	44%	26%	10%	10%	10%
Christchurch	7%	17%	7%	43%	27%
West Dorset	5%	19%	39%	23%	14%
East Dorset	2%	9%	7%	21%	61%
Purbeck	0%	24%	31%	34%	10%
North Dorset	0%	14%	29%	29%	29%
Dorset	21%	18%	18%	20%	23%
UK	20%	20%	20%	20%	20%

<http://www.dorsetforyou.com/index.jsp?articleid=327806>

7.5 The Audit Commission either needs to abstain from judging the provision of medical services, as it is currently only capable of accountancy and not public health consideration, or urgently seek new public health expertise into its structure.

8.0 *Whether the Government is likely to meet its Public Service Agreement targets in respect of Health Inequalities.*

8.1 Some targets such as teenage pregnancy rates are iconic for wealth inequality. Any efforts to reduce the numbers of a few chosen indicators in isolation do not really solve the fundamental underlying injustice of growing wealth disparities.

8.2 A car heading the wrong way may show some red warning indicators. The assumption in picking a few easy NHS public agreement targets is like these lights on the national dashboard. The aim seems to be to put masking tape on the indicators or remove the bulbs and then carry on in the same direction. The chosen route being one of increasing wealth inequalities with a widening gap between the rich and poor.

8.3 The Health Inequalities measures are just indicators of the wealth inequalities. If one is serious about reversing these then reverse the national car and travel in a different direction.

8.4 Thus the government may meet its Public Service Agreement targets yet do little to really act justly to reverse Inequalities.

January 2008

Memorandum by the South Asian Health Foundation (HI 18)

HEALTH INEQUALITIES

BACKGROUND

The South Asian Health Foundation (SAHF) aims to promote improvements in the quality of, and access to, healthcare and health promotion in South Asians. The organisation achieves this by 3 main mechanisms

- Promotion of high quality scholarship and research
- Health promotion and education at a grassroots level to communities
- Health advocacy via interaction and advisory input into organisations and processes such as those at NICE

SAHF has a council of respected clinicians, both academic and non academic, from a variety of disciplines, enabling the organisation to effectively address the challenges of health inequalities and related issues pertinent to ethnic communities. Further information about the organisation may be obtained either via the website www.sahf.org.uk or annual reports submitted to the charities commission.

EXECUTIVE SUMMARY

We shall cover the specific sections within the remit with particular focus on the following key themes:

- A. Variations in disease prevalence by ethnic group
- B. Access to services—south Asian GPs in inner city areas providing the majority of care (so far in terms of language) and the implications of their retirement.
- C. New pressures from recent and current migration..
- D. Need for more comprehensive ethnic recording to systematically monitor services
- E. Training of healthcare staff

INTRODUCTION

The UK has seen a substantial increase in prosperity over the past decade but the same cannot be said for health. Health and wealth are inextricably linked, but wealth is not the sole driver of inequalities in health.¹³³ For many years studies have suggested that there are inequalities in health between different ethnic groups and different socioeconomic groups, both in the UK and in the USA.¹³⁴ In the USA, claims for these inequalities are generally supported by reliable data whereas, in the UK, a clear picture is problematic due to lack of systematic collection of ethnic group data. For example, country of birth is recorded on a death certificate rather than ethnic group, so using this method to collate mortality statistics gives an inaccurate and incomplete picture of ethnicity and mortality, as it does not account for ethnicity of people born in this country.^{135, 136} Such a minor misinterpretation of ethnicity, country of origin rather than self reported ethnicity, provides the cornerstone for inaccurate data upon which health policy and strategy are based.

1. *The extent to which the NHS can contribute to reducing health inequalities, given that many of the causes of inequalities relate to other policy areas eg taxation, employment, housing, education and local government.*

The evidence base for the marked inequalities in health and health care is well established for the general population as well as Black and minority ethnic groups.¹³⁷ For example, south Asians are 50% more likely to die from coronary heart disease (CHD). Reasons for this are multifactorial and incompletely understood,^{138, 139} but a central tenet is that the increased mortality rates are related to poverty or socio-economic deprivation, since those worst affected are from poorer groups eg those from Pakistani and Bangladeshi backgrounds.^{137, 140} Mortality from heart disease is almost five fold higher in unskilled men than skilled men.¹³³

Despite Government efforts directed at reducing health inequalities, there is still substantial progress to be made and there are on the horizon, further challenges posed by migration from eastern Europe.¹⁴¹ Even within the indigenous population of England, health inequalities remain, such as the marked north-south divide in cardiovascular morbidity and mortality.¹⁴²

The NHS has a central role to play in reducing inequalities in health by its instrumental role in not only diagnosis and treatment of disease, but also its emerging role in large scale prevention of disease. However given that the main causes of morbidity and mortality are multifactorial, hence external to NHS control, it is vital that there is interlinked strategy and policy between government departments. A prime example is tobacco related ill health. There is firm evidence that taxation and legislation have had a dramatic effect on reducing overall smoking amongst the general population^{143, 144} and legislation to provide smoke free public places has translated into a health benefit by reducing the rate of myocardial infarction in Scotland by 17% in 12 months. Such a phenomenon is not confined to Scotland, since similar health benefits have been described in the Republic of Ireland. However despite such positive improvements at a population level, it

¹³³ Acheson D. Independent Inquiry into Inequalities in Health. The Stationery Office: London, 1998.

¹³⁴ Bhopal RS. Ethnicity, Race, and Health in Multicultural Societies. Oxford University Press: Oxford, 2007.

¹³⁵ Aspinall P, Jacobson B. Ethnic Disparities in Health and Health Care: A focused review of the evidence and selected examples of good practice. London Health Observatory: London, 2004.

¹³⁶ Gill PS, Bhopal R, Wild S, Kai J. Limitations and potential of country of birth as proxy for ethnic group. *BMJ* 2005; 330: 196.

¹³⁷ Gill PS, Kai J, Bhopal RS, Wild S. Health Care Needs Assessment: Black and Minority Ethnic Groups. In Raftery J, Stevens A, Mant J (eds) Health Care Needs Assessment: The epidemiologically based needs assessment reviews. Third series. Abingdon: Radcliffe Medical Press, 2007.

¹³⁸ KCR Patel, RS Bhopal (eds). The Epidemic of Coronary Heart Disease in South Asian Populations: Causes and Consequences. South Asian Health Foundation; Birmingham, 2004.

¹³⁹ KCR Patel, AM Shah (eds). Prevention, Treatment and Rehabilitation of Cardiovascular Disease in South Asians. The Stationery Office: London, 2005.

¹⁴⁰ Lip GYH, Barnett AH, Bradbury A, Cappuccio FP, Gill PS, Hughes E, Imray C, Jolly K, Patel K. Ethnicity and cardiovascular disease prevention in the United Kingdom: a practical approach to management. *J Hum Hyper* 2007; 21: 183–211. <http://www.nature.com/jhh/journal/v21/n3/pdf/1002126a.pdf>.

¹⁴¹ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_079716.

¹⁴² <http://www.heartstats.org/datapage.asp?id=6799>.

¹⁴³ Haw SJ, Gruer L. Changes in exposure of adult non-smokers to secondhand smoke after implementation of smoke-free legislation in Scotland: national cross sectional survey *BMJ* 2007; 335: 549.

¹⁴⁴ Akhtar PC, Currie DB, Currie CE, Haw SJ. Changes in child exposure to environmental tobacco smoke (CHETS) study after implementation of smoke-free legislation in Scotland: national cross sectional survey. *BMJ* 2007; 335: 545.

would be naïve to imagine that all socioeconomic and ethnic groups have benefited equitably from such legislature. Therefore, in order to tackle health inequalities, certain strategies and policies may require tailoring to specifically meet the demands of groups victim to inequalities in health.

The collaborative approach of government departments is essential to tackle the root cause of health inequalities that reside in poverty, transport, employment, education and adverse health behaviours. The ability of the National Institute of Health and Clinical Excellence to commence developing guidance on Public Health Interventions has been a significant positive step in tackling health inequalities and the breadth of input into such guidance from a variety of governmental and non-governmental agencies is an example of positive steps aimed at facilitating the amelioration of inequalities.

2. The distribution and quality of GP services and their influence on health inequalities, including how the Quality and Outcomes Framework and Practice-based Commissioning might be used to improve the quality and distribution of GP services to reduce health inequalities.

We know that variations by disease exist between the majority and minority ethnic groups in the UK.¹⁴⁵ The main determinant of these health inequalities is how society is organised, in particular because of inequalities in income between different groups. Tackling the underlying determinants of health inequalities requires redistribution of wealth and/or amelioration of poverty.

Geographical distribution of GPs is highly variable with lower numbers per capita in the North of England than in the relatively wealthy South-east. Even within conurbations, inner-city areas tend to have more single handed GPs than suburban areas. An inverse care law exists, in that the inner city areas commensurate with highest levels of deprivation and ill health, tend to be the most poorly served in terms of access to GP services and providers. Inner city GPs also tend to be over-represented in their composition by GPs who have qualified from overseas—mainly the Indian subcontinent.¹⁴⁶ These GPs provide communication in a mother tongue and are likely to comprehend the health needs and somatisation of patients from a similar ethnic group, possibly suggesting that this ethnic composition of GPs in inner cities is not deleterious and might in some instances be beneficial. However, the large majority of these doctors will retire from the NHS within next 5–10 years and vacancies are likely to be filled by commercially orientated providers unprepared for providing culturally competent care.¹⁴⁷ The government drive to larger practices is well principled but not an evidence based reform of services.

Since April 2004, general practitioners in the UK have been remunerated for recording a number of process and intermediate outcome measures. The Quality and Outcomes Framework has achieved much and “situates health inequalities at the level of the individual and ignores the political, social and cultural context within which people find themselves”.¹⁴⁸ It is questionable whether the QoF has truly delivered both quality and developed a framework to tackle inequalities in health. The latter is indisputable in that all GPs now have a framework upon which to systematically record data and drive interventions. However, those individuals not accessing services are not served an advantage by QoF as proactive case finding is essential to derive access to healthcare for those most at risk. There is considerable evidence that both population level health interventions and quality improvement initiatives result in the greater benefits for those providers and populations who already have high initial baseline levels of provision.

The introduction of practice based commissioning poses specific challenges yet offers considerable opportunities too. It is plausible that areas with more fragmented service provision such as urban conurbations may not see service provision progress at the same rate as those where organisation, co-ordination, disease burden and resources are relatively more generous.

If we do not understand the full extent of ethnic inequalities in health, we can neither investigate underlying causes nor consider possible solutions. Whilst in secondary care it has been mandatory to record ethnicity on all patients since 1995, in primary care there has been no requirement of this kind at national level.¹⁴⁹ Indeed, even in secondary care, there is still considerable variation in the completeness of ethnic coding of patients. For example in 2001, only 61.3% of Hospital Episode Statistics had valid ethnic coding.¹⁵⁰ Additionally, patient satisfaction surveys continue to struggle at identifying levels of and barriers to patient satisfaction from ethnic groups.¹⁵¹

¹⁴⁵ Gill PS, Kai J, Bhopal RS, Wild S. Health Care Needs Assessment: Black and Minority Ethnic Groups. In Raftery J, Stevens A, Mant J (eds) Health Care Needs Assessment: The epidemiologically based needs assessment reviews. Third series. Abingdon: Radcliffe Medical Press, 2007.

¹⁴⁶ Gill PS. General practitioners, ethnic diversity and racism. In: Coker N (ed). Racism in Medicine: An agenda for change. King's Fund: London, 2001.

¹⁴⁷ Taylor Jr DH, Esmail A. Retrospective analysis of census data on general practitioners who qualified in South Asia: who will replace them as they retire? BMJ 1999; 318: 306–310.

¹⁴⁸ Heath I, Hippisley-Cox J, Smeeth L. Measuring performance and missing the point? BMJ 2007; 335: 107576.

¹⁴⁹ Gill PS, Johnson MRD. Ethnic monitoring and equity. BMJ. 1995; 310: 890.

¹⁵⁰ Aspinall P, Jacobson B. Ethnic Disparities in Health and Health Care: A focused review of the evidence and selected examples of good practice. London Health Observatory: London, 2004.

¹⁵¹ Sheldon H, Rasul F. Increasing response rates amongst Black and Minority Ethnic and seldom heard groups. A review of the literature relevant to the National Acute Patients' Survey. Oxford: Picker Institute, 2006.

Migration is a dynamic and complex process and indeed ethnic diversity is not new to the UK. People with different histories, cultures, beliefs and languages have been coming to the UK since the first millennium BC.¹⁵² The 2001 Census showed that 7.9% of the population in the UK were from a Black or minority ethnic background.¹⁵³ They reside throughout the UK with concentration in urban areas such as Birmingham (29.8%), Leicester (36.2%), and Tower Hamlets (48.6%). Indeed it is predicted that Birmingham and Leicester will become “majority-minority” cities (where the majority of the population come from minority ethnic backgrounds) within a decade.¹⁵⁴ The UK has seen new waves of immigration during the past six years, notably from an enlarged European Economic Union and from countries affected by war, such as Somalia and Iraq. Accurate information on populations served by PCTs is essential for services to be equitable and appropriate, a huge challenge when the current level of inequalities in health is considered.

Increased global migration has increased linguistic diversity in major cities and increased need for interpreting services. Language barriers remain a major barrier to accessing health. However, there is a dearth of data on this and it has been estimated that there are over $\frac{1}{2}$ million individuals, from the 4 established ethnic communities (ie Indian, Pakistani, Bangladeshi and Chinese), who are unable to converse with a health professional (Gill, personal communication). This is an underestimate and does not include refugees, asylum seekers or the recent migrants.

It is recommended that:

- all primary care staff are trained for ethnic monitoring and how to derive self reported ethnicity. Recording at birth for all new births and at first GP registration for all patients, with phased introduction of data collection for all age groups.
- to extend ethnic data collection to include religion and preferred communication portals—both verbal and written.
- Access is not the sole driver to obtaining better healthcare, but must form part of the pathway of awareness, access and acquisition of healthcare. Simply providing a service does not necessarily mean individuals will benefit from that service. A proactive and personalised NHS is essential to reducing inequalities in health.

This is not to exclude one of the prime objectives of citizenship, that effort must be made to integrate within a multicultural society. We firmly believe that isolation of communities and sections of society are patterns of behaviour which in themselves, serve to perpetuate both organic and inorganic health inequalities. There is no place in the society of multicultural Britain for advocated isolation of ethnic minority groups. Integration into all streams of life and activity should be encouraged and facilitated by both the democracy and the societies themselves.

3. The effectiveness of public health services at reducing inequalities by targeting key causes such as smoking and obesity, including whether some public health interventions may lead to increases in health inequalities; and which interventions are most cost-effective.

There are 4 positive aspects of public health policy development and implementation which have served to ameliorate inequalities

1. The establishment of “Spearhead PCTs” where 44% of the BME population reside. These areas have the poorest health and socioeconomic profile in England.
2. NICE Public Health Guidance with an emphasis on ethnicity and tackling health inequalities for smoking cessation has enabled the much neglected area of smokeless tobacco use to be placed high on the agenda for PCTs in high ethnic areas. A further example is the development of specific guidance to tackle inequalities eg “interventions to reduce the rates of premature death in disadvantaged areas.”
3. The input of non-governmental organisations such as SAHF into policy development has meant that these traditionally perceived “hard to reach groups” might not be so hard to reach after all. The development of portals of communication from a grass roots level has been beneficial to tailored policy and strategy.¹⁵⁵
4. Audit and monitoring within the Health Service has identified specific areas of inequalities eg South Asian patients considered to be suitable candidates for revascularisation were less likely to be referred for this procedure than white European patients in a report from London.¹⁵⁶ Outcomes relating to CVD can now be stratified according to ethnic status.

¹⁵² Gill PS, Kai J, Bhopal RS, Wild S. Health Care Needs Assessment: Black and Minority Ethnic Groups. In Raftery J, Stevens A, Mant J (eds) Health Care Needs Assessment: The epidemiologically based needs assessment reviews. Third series. Abingdon: Radcliffe Medical Press, 2007.

¹⁵³ Population Census 2001. Office for National Statistics.

¹⁵⁴ Slater TR. Birmingham's Black and South-Asian population. In Gerrard AJ, Slater TR (eds). Managing a Conurbation: Birmingham and its Region. Studley: Brewin Books, 1996.

¹⁵⁵ Patel KCR. Transcript of oral evidence to the Health Select Committee 2007

<http://www.publications.parliament.uk/pa/cm200607/cmselect/cmhealth/uc503-ii/uc50302.htm>.

¹⁵⁶ Feder G, Crook AM, Magee P, Banerjee S, Timmis AD, Hemingway H. Ethnic differences in invasive management of coronary disease: prospective cohort study of patients undergoing angiography. BMJ 2002; 324: 511–6.

5. The frequent publication of communications which keep health inequalities on the agenda for healthcare delivery.^{157,158, 159, 160, 161, 162}
 6. Race Impact Assessments to be performance managed
4. *Whether specific interventions designed to tackle health inequalities, such as Sure Start and Health Action Zones, have proved effective and cost-effective.*

We are unaware of specific outcome measures for such programmes.

5. *The success of NHS organisations at co-ordinating activities with other organisations, for example local authorities, education and housing providers, to tackle inequalities; and what incentives can be provided to ensure these organisations improve care.*

The UK remains a markedly unequal society, ranked 21st out of the 27 countries of the European Union in terms of the proportion of the population living in relative poverty.¹⁶³ In these adverse circumstances, health opportunities will be substantially altered only by genuine political and social change; with local authority, education, housing, social care and the NHS working together to deliver care to their residents. At present, it is our opinion that NHS organisations have very limited impact, probably justifiably, in terms of dictating other aspects of local authority activity. What is required is not an NHS led society, but a society in which there is a multi-agency, inter-linked policy and strategy enterprise, with multi-agency implementation. The current drive to fiscal constraint and “efficiency” within the NHS appears to be at odds with a joined up approach to healthcare and illness prevention at a multi-agency level, since the responsibilities of multiple agencies clearly overlap and fiscal delineation of responsibility is extremely difficult.

6. *The effectiveness of the Department of Health in co-ordinating policy with other government departments, in order to meet its Public Service Agreement targets for reducing inequalities.*

The Department of Health is clearly aiming towards reducing health inequalities but given limited cross-departmental collaboration, the overall impact on health inequalities is severely restricted eg drives to tackle obesity are hampered by legislation ineffective at mandating accurate food labelling clear to the consumer. One area where the Department of Health is working effectively at tackling inequalities in CVD is by close working with the Cardiovascular Coalition, a coalition of over 30 non governmental organisations with an objective to tackle CVD.

7. *Whether the Government is likely to meet its Public Service Agreement targets in respect of health inequalities.*

In some areas such as CVD, targets will be met by 2010, and many argue these targets would have been met by the natural decline in disease rates. However, the National Service framework for CHD was the single most important factor in delivering better CVD care since the inception of the NHS. In other areas, eg teenage pregnancy, perinatal mortality and smoking there appear to be widening inequalities with South Asians faring worse than other ethnic groups. Significant contributions to the reduction in CVD prevalence are expected as a result of recent legislation banning smoking in public places, however, due to cultural preferences this impact is unlikely to be seen amongst south Asian groups,

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January 2008

¹⁵⁷ Choosing Health (Department of Health 2004).

¹⁵⁸ Tackling Health Inequalities: a programme for action (Department of Health 2003).

¹⁵⁹ National Standards Local Action (Department of Health 2004).

¹⁶⁰ Strong and Prosperous Communities: the local government white paper (DCLG 2006).

¹⁶¹ Wanless report: securing good health for the whole population (Wanless 2004).

¹⁶² Making the connections: final report on transport and social exclusion (SEU 2003).

¹⁶³ Heath I. Let's get tough on the causes of health inequality. BMJ2007; 334.

¹⁶⁴ General Practitioner and Clinical Reader in Primary Care Research, University of Birmingham and Regional Patron to SAHF.

¹⁶⁵ Consultant Cardiologist and Honorary Senior Lecturer, Sandwell & West Birmingham NHS Trust and University of Birmingham; Chairman of Trustees to SAHF.

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**Memorandum by the Clinical Effectiveness and Evaluation Unit (CEEU), Royal College of Physicians'
Clinical Standards Department (HI 19)**

THE CONTRIBUTION OF THE NHS TO REDUCING HEALTH INEQUALITIES

1.0 EXECUTIVE SUMMARY

1.1 The inequitable provision of appropriate care for people suffering from fall-related fragility fractures in the UK has led to unacceptably high rates of mortality and morbidity, and significant financial and social care costs. Interventions to reduce falls have been defined by national guidance. Treatments for osteoporosis, especially following a fragility fracture, have been shown in research to reduce future fracture risk and have been shown to be both clinically and cost effective by the National Institute for Health and Clinical Excellence (NICE).

1.2 Evidence from a nationally representative evaluation in primary care suggests these interventions are poorly and unevenly delivered across the NHS leading to unacceptable inequity of access to high quality care based on age, sex and geographical location. Evidence from the National Clinical Audit of Falls and Bone Health shows an unacceptable degree of variation across the NHS.

1.3 Change is possible through existing commissioning structures and the Quality and Outcomes Framework in line with recommendations made through studies commissioned by the Healthcare Commission and the Information Centre.

1.4 The Health Select Committee should recommend to the Secretary of State for Health that indicators submitted for osteoporosis care are included within QOF in 2008 and that fully integrated services for high risk fallers and secondary fracture prevention are commissioned by primary care. Evidence suggests that implementing these recommendations will significantly reduce health inequalities for this patient population.

1.5 The evidence base and national guidance could now be considered so authoritative that persistent inequalities in access to and delivery of care represent a medico-legal risk to Trusts.

2.0 INTRODUCTION

2.1 Osteoporosis and falls have a major impact on health and social care utilisation principally through the consequent low trauma fractures, especially those of the hip. 95% of hip fractures follow a fall. Data that is now nearly ten years old suggests the combined cost of social and hospital care for patients with osteoporotic fractures is approximately £1.8 billion per year in the UK. More contemporary evidence suggests this is much higher. Fractures in over 60 year olds involve more than two million bed days in England alone, and another two million are taken up by frailty related falls in patients over the age of 75. Half of people surviving a hip fracture can no longer live independently as a result of the injury.

2.2 Perhaps more important is the impact on personal health and quality of life. These burdens are set to rise rapidly in the next two decades due to increased longevity. Hip fractures are set to rise from a bit under 70,000 to 100,000 per year in England by 2020 at the present rate of growth. Falls admissions in the over 75s have risen by more than 10% per year between 2004 and 2006.

2.3 In 2001 the National Service Framework for Older People outlined standards for the management of fallers and those at risk of future osteoporosis related fracture. National guidance has been provided by NICE on a clinically effective approach to fallers and a Health Technology Appraisal has been published demonstrating the clinical and cost effectiveness of pharmacotherapeutic interventions in the secondary prevention of fractures in post-menopausal women. Evidence based medicine and national guidance supports interventions for other groups such as men with a low trauma fracture, the elderly housebound, those in residential care, and a number of other high risk groups. These interventions have been linked to clinically and cost effective reductions in consequent fractures and therefore health and social care utilisation, admissions and personal morbidity and mortality.

2.4 However published research and more recent government reports including those from the CEEU¹⁶⁸, ¹⁶⁹ and the Information Centre,¹⁷⁰ have indicated that services are poorly integrated, see few patients and that most in these risk groups do not benefit from high quality systematic care as outlined in national guidance and that there is an unacceptable level of variance between Trusts and between practices. These variances exist despite high self-reported standards of compliance by NHS trusts and lead to differential access to care depending on where the patient lives, their age and sex.

¹⁶⁸ The Clinical Effectiveness and Evaluation Unit: Royal College of Physicians' London. National Audit of the Organisation of Services for Falls and Bone Health for Older People.; 2006.

¹⁶⁹ Clinical Effectiveness and Evaluation Unit. National Clinical Audit of Falls and Bone Health. London; 2007 November 2007.

¹⁷⁰ Hippisley-Cox J, Bayly J, Potter J, Fenty J, Parker C. Evaluation of standards of care for osteoporosis and falls in primary care: The Health and Social Care Information Centre; 2007.

2.5 The proportion of hip fractures sustained by men is increasing. Men have a higher mortality and morbidity than women following low trauma fracture. Though men benefit equally from attention to bone health they very rarely receive such care when compared to women.

2.6 The distribution and quality of GP services for patients at risk of fractures because of poor bone health and falls risk could be improved through a more systematic approach to management driven by the adoption of indicators for osteoporosis in the Quality and Outcomes Framework (QOF).

2.7 Similarly improvements in the initial management of fallers who have fractures could be expedited by requiring commissioners (whether practice or PCT based) to ensure Fracture Liaison Services are in place in all acute hospital trusts as recommended in five government funded reports.^{171, 172, 173, 174, 175}

2.8 More than 40% of hip fracture patients will have experienced a prior fragility fracture. The evidence based national guidance aimed at preventing second and subsequent fractures could now be considered so authoritative that failure to equitably organise, offer or deliver such interventions could represent a medico-legal risk to NHS Trusts. Long term institutional care is common following hip fracture. The costs are large and frequently are funded through equity release of the patient's principal residence. There is a possibility that dependent relatives may seek to recover lost inheritable assets through the courts if it were established that NHS Trusts had not put systems in place, or that minimal standards of care had not been delivered by Trust staff, that might have avoided the hip fracture that followed the earlier presenting fragility fracture.

3.0 EVIDENCE

3.1 *Evidence from secondary care: National Clinical Audit of Falls and Bone Health*¹⁷²

This study was commissioned by the Healthcare Commission. It measured how well care was being delivered in England, Wales and Northern Ireland to over 65 year old patients presenting to casualty departments with a hip or other non-hip fragility fracture (of the arm, pelvis or spine) following a fall. It evaluated standards in orthopaedic and ortho-geriatric care for hip fracture patients as well as how well secondary fracture prevention and falls interventions were documented for all fracture types. There was an unacceptable degree of variation across the NHS that inevitably means inequalities of access to high quality care based upon the Hospital Trust responsible for service provision in the area where the patient lives.

3.1.1 It was found that self-reported organisational audit achievements are not a good predictor of measured achievement and cannot be relied upon as there is poor correlation with overall clinical process scores.

3.1.2 The clinical audit provided a performance score for each hospital site for differing domains of care eg assessment, management and secondary prevention [examples include: did people get referred to a falls service, did people get treatment to prevent osteoporosis]. The mean score is the mean of the scores for each domain and has a scale of 0–100. Anonymous clinical audit quality scores for different hospital sites are represented by the points in figures 1.1 and 1.2 below. They are presented in a series of rows corresponding to different SHAs. A wide variation in performance is seen across the authorities.

¹⁷¹ The Clinical Effectiveness and Evaluation Unit: Royal College of Physicians' London. National Audit of the Organisation of Services for Falls and Bone Health for Older People.; 2006.

¹⁷² Clinical Effectiveness and Evaluation Unit. National Clinical Audit of Falls and Bone Health. London; 2007 November 2007.

¹⁷³ Hippisley-Cox J, Bayly J, Potter J, Fenty J, Parker C. Evaluation of standards of care for osteoporosis and falls in primary care: The Health and Social Care Information Centre; 2007.

¹⁷⁴ McLellan Alastair R., Reid DM, Forbes K, Reid R, Campbell C, Gregori Alberto, et al. Effectiveness of Strategies for the Secondary Prevention of Osteoporotic Fractures in Scotland (CEPS 99/03): NHS Quality Improvement Scotland; 2004.

¹⁷⁵ Department of Health. Musculoskeletal Services framework. Available from <http://www.18weeks.nhs.uk/cms/ArticleFiles/gm5hdlexqmhakbqwwzzxfb32t19102005124130/Files/MSF.pdf> [Last accessed 2 January 2008]; 2006.

Figure 1.1 Mean overall clinical audit scores for non-hip fractures by hospital site and SHA

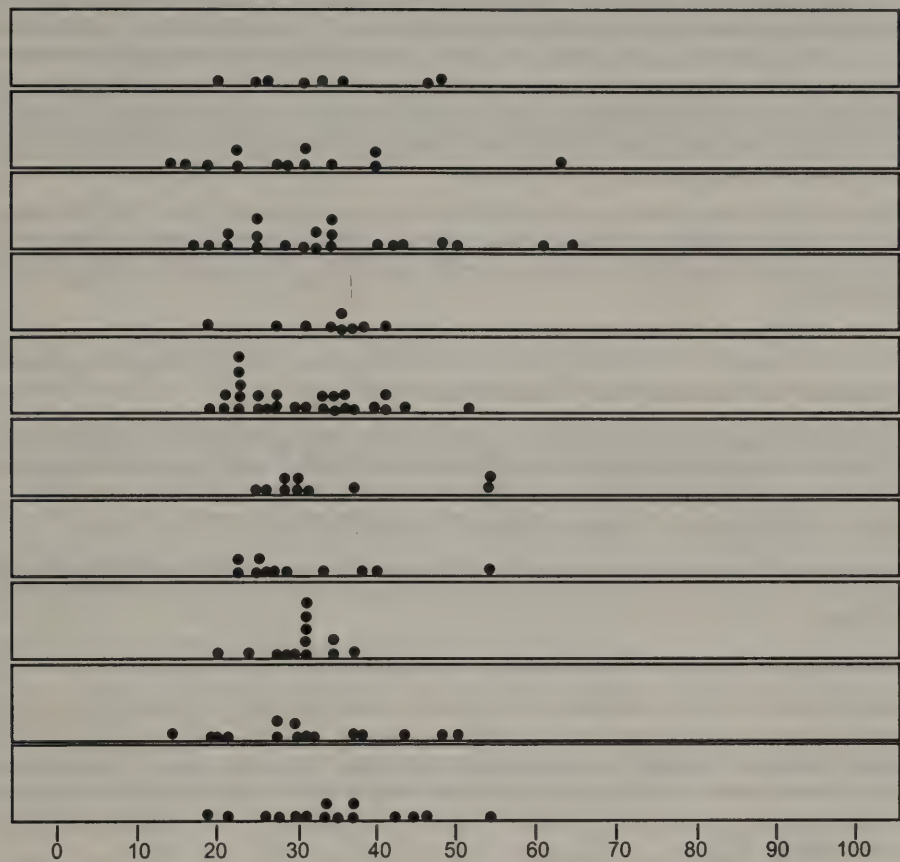
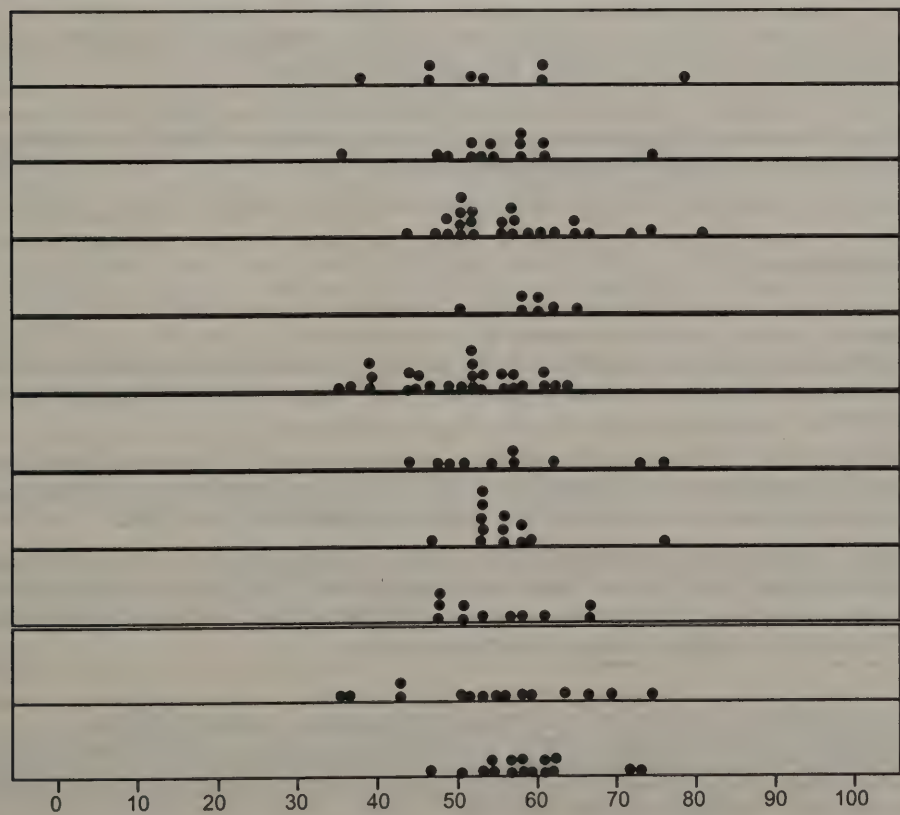


Figure 1.2 Mean overall clinical audit scores for hip fractures by hospital site and SHA



3.1.3 Non hip fractures related to a fall are potent predictors of future hip fracture. The hip fracture is the costliest to the patient and to society. Almost half of hip fracture patients will have already sustained at least one previous fracture which in the overwhelming majority of cases will not have received investigation or treatment. A NICE Technology Appraisal Guideline has strongly endorsed investigations and clinically and cost-effective pharmacological treatments to reduce the risk of future fracture. Overall performance in delivering this guidance aimed at improving bone health was measured. One quarter of Trusts had a score below 35.1% while the best performing quartile had a score in excess of 49.7%. Three sites were in the range 80–100%.

3.1.4 Fallers who have sustained a non-hip fracture are clearly a priority for a falls risk assessment and interventions as recommended by a NICE. One quarter of Trusts achieved a score of less than 19% while the best performing quartile achieved a score of 34.9% or higher. The top three Trusts achieved a score between 60 and 80%.

3.2 Further evidence from secondary care: *Fracture Liaison Services*

3.2.1 The Fracture Liaison Service consistently implements a care pathway to identify and intervene with patients presenting to hospitals with fragility fractures following falls. A designated health care professional identifies these patients in trauma departments, fracture clinics, and the wards. He or she initiates secondary fracture prevention according to management algorithms derived from NICE guidance.

3.2.2 These services have been shown in published research¹⁷⁶ and audit¹⁷⁷ to be far superior to any other model in terms of delivering nationally endorsed interventions to patients presenting with fragility fractures to secondary care

3.2.3 However, as few as one in four hospital trusts have a person in place to deliver such services.

3.2.4 Fracture Liaison Services will only ever be able to identify the new, incident fracture. Only primary care can identify the patient with the historical fragility fracture. It is well recognised that, as with all long term conditions that are not primarily symptomatic, persistence with treatments for osteoporosis is poor with as many as 50% of patients discontinuing treatment within the first twelve months. For these reason it is essential fracture liaison services are backed up with case-finding and continuing care provision in general practice through the QOF.

3.3 Evidence from primary care *An Evaluation of Standards for Osteoporosis and Falls in Primary Care*¹⁷⁸

3.3.1 This study was commissioned by the Information Centre. It examined documented standards in the GP electronic records in a nationally representative population of 3.4 million covered by 487 practices. Inequalities of access to optimal care across the country, between different age groups and between men and women were identified in a number of criteria and are reported below.

3.3.2 As with the national clinical audit, standards largely fell a long way below optimum care and there was wide variation between practices that is not explained by population variations and which again would lead to inequity of access depending on geographical location.

3.3.3 One quarter of the practices could only identify 0.7% of the population as having osteoporosis while the best performing quartile achieved more than double this (1.5%). The true prevalence is likely to be at least double this figure.

3.3.4 Patients living in a residential or care home setting are at a very high risk of hip fracture. It is recommended they receive calcium and vitamin D3 supplementation as it has been shown to nearly halve this risk. One quarter of practices could identify no patients in this risk group receiving supplementation whereas the best quartile could demonstrate nearly half or more of these patients in receipt of supplementation.

3.3.5 Women aged 75 years or over with a prior fragility fracture are strongly recommended to be treated with a specific osteoporosis therapy by NICE guidance. One quarter of practices could only demonstrate that 18% received guideline care whereas the best performing quartile achieved 32%.

3.3.6 Women aged between 65 and 74 years with a prior fragility fracture are strongly recommended by NICE to be referred for DXA scan to assess future fracture risk. One quarter of practices could only demonstrate that one in twenty had received a scan whereas the best performing quartile had evidence of a scan in 12.5%, more than double the rate in the lowest quartile.

¹⁷⁶ McLellan A, Gallacher S, Fraser M, McQuillan C. The fracture liaison service: success of a program for the evaluation and management of patients with osteoporotic fracture. *Osteoporosis International*. 2003;14(12):1028–34.

¹⁷⁷ McLellan Alastair R., Reid DM, Forbes K, Reid R, Campbell C, Gregori Alberto, et al. Effectiveness of Strategies for the Secondary Prevention of Osteoporotic Fractures in Scotland (CEPS 99/03): NHS Quality Improvement Scotland; 2004.

¹⁷⁸ Hippisley-Cox J, Bayly J, Potter J, Fenty J, Parker C. Evaluation of standards of care for osteoporosis and falls in primary care: The Health and Social Care Information Centre; 2007.

3.3.7 Men over 65 who suffer a fragility fracture carry a higher risk of morbidity and mortality than women. However, following a prior fragility fracture they are five times less likely to have evidence of an assessment of future fracture risk by DXA scan (mean 1.8%, 95% confidence intervals 1.6–2.0 versus 9.8%, confidence intervals (CI) 9.4–10.3 for women).

3.3.8 Older women with a prior fragility fracture are less likely to receive guideline care than those younger. Where identified, women with a prior fragility fracture aged 65–74 years are much more likely to receive interventions strongly recommended by NICE guidance than women aged 75 years or more with the same risk (73%, 95% confidence intervals 71.2–74.7 versus 25.3%, 95% confidence intervals 24.8–25.8)

3.4 Further evidence from primary care: uneven care can exist across healthcare communities¹⁷⁹

3.4.1 Systematic and structured care pathways for patients at risk of falls related fracture have not been adopted, monitored or performance managed across the NHS. This has led to inequalities of access to care as demonstrated by measurable proxies of improved outcomes even within health care communities.

3.4.2 An active case-finding programme for patients at high risk of falls and osteoporotic fracture was delivered to a population of 80,000 within Gloucestershire between the years 2000 and 2003. In 2006 persisting standards of care were compared in this population against a control group comprising 430,000 patients in the rest of the county receiving normal care. In nearly all respects the standards were significantly higher ($p < 0.0001$) in the intervention arm even in the absence of an ongoing programme during the previous three years. Examples follow.

3.4.3 Women over 75 years with prior fragility fracture four times more likely to have had a recent osteoporosis treatment or assessment (OR 4.15, 95% CI 3.35–5.13)

3.4.4 Women aged 65–74 years with a prior fragility fracture were six times more likely to have had a DXA scan (OR 6.10, 95% CI 3.88–9.61).

3.4.5 Identified high risk fallers over 75 years were four times more likely to have been referred to a falls clinic (OR 4.35, 95% CI 3.03–6.23) or thirteen times more likely to have had an osteoporosis assessment (OR 13.63, 95% CI 8.30–21.88)

3.4.6 Patients over 75 years of age with a prior fragility fracture were nine times more likely to have had a falls assessment (OR 9.37, 95% CI 7.04–12.49).

4.0 RECOMMENDATIONS

4.1 The inequalities identified in this memorandum should be seen in the context of the overall low standards of care in the management of older patients at risk of falls and osteoporosis related fractures. This is supported by evidence from published research and national and other large scale audits of care.

4.2 The solution to both the inequalities and the overall low standards is possible within current commissioning processes and the Quality and Outcomes Framework. Submissions to the QOF Expert Review Group in this area have been made by the National Osteoporosis Society and the British Geriatrics Society.

4.3 The Health Select Committee should alert the Secretary of State for Health as to the possible medico-legal risk NHS Trusts bear by not adequately responding to the inequalities of access to care identified in published studies.

4.4 The Health Select Committee should endorse the recommendations made in the reports from the CEEU and the Information Centre, specifically recommending to the Secretary of State for Health that

4.4.1 A domain for osteoporotic fracture prevention should be included within the QOF in 2008 as a priority. The contents of this memorandum should be fed in to the current consultation process concerning the re-structuring of the General Medical Services contract and the negotiations between the GPC and NHS Employers concerning the QOF.

4.4.2 Primary Care should commission a patient care pathway for the secondary prevention of falls and fractures that includes a Fracture Liaison service that targets the high risk group of patients presenting with a first fragility fracture.

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¹⁷⁹ Bayly JR, Hollands RD, Yemm SJ, Riordan-Jones SE, Brough-Williams I, Thatcher M, et al. Does an osteoporosis and falls case-finding programme in a UK primary care setting lead to lasting improvements in measured standards of care when compared to usual practice? *Calcified Tissue International*. 2007;80 Supplement 1 (May):S116.

Memorandum by Weight Watchers (UK) Ltd (HI 20)

HEALTH INEQUALITIES

EXECUTIVE SUMMARY

- Obesity is a key factor in health inequalities
- Weight Watchers focuses on long-term lifestyle changes and is effective
“But Weight Watchers is right” (Will Hutton, *The Observer*, 2 December 2007).
- Referral schemes make Weight Watchers more accessible to vulnerable groups
- Tailoring Weight Watchers for South Asian communities

1. OBESITY IS A KEY FACTOR IN HEALTH INEQUALITIES

1.1 Obesity is a key factor in health inequalities in the UK (Foresight Report, 2007), where the prevalence of obesity in low income families, South Asian immigrants and the elderly is particularly high.

1.2 By 2050, 50% of women and 60% of men in the UK will be obese. In the future, being overweight will be the norm (Foresight, 2007).

1.3 The social class gradient of obesity is very strong and particularly pronounced in women. This means that more people in low income families suffer from obesity than families in higher income brackets (Foresight, 2007).

1.4 South Asians in the UK have higher rates of central obesity, higher blood pressure and greater risk of stroke than the general population. In addition South Asians seem to develop these diseases at lower Body Mass Indices (BMIs) than Europeans, so weight control in this immigrant population becomes vital for protecting health in the longer term (Health Survey for England).

1.5 The data from the Health Survey for England shows an upward shift in the incidence of obesity across age groups. The highest levels of obesity are in men and women in the 55–64 age bracket, and this is maintained as people move into retirement and their 70s (Health Survey for England).

1.6 The Foresight report recently recommended that treatment and prevention must go hand in hand for a sustainable response to obesity. Weight Watchers spans both approaches as it “treats” people with established weight problems but also helps its members establish healthy lifestyle habits which they can then take home to their family environments.

2. WEIGHT WATCHERS FOCUSES ON LONG-TERM LIFESTYLE CHANGES AND IS EFFECTIVE

2.1 In the UK Weight Watchers runs over 6,500 meetings per week, seven days a week. The key to Weight Watchers’ service is accessibility, so times of meetings and familiar venues such as village halls and community centres are all utilised to make it easy for members to attend.

2.2 The Weight Watchers approach is based on the NICE good practice guidelines (NICE, 2006) in:

- aiming for a modest maximum weekly weight loss of 0.5–1 kg
- providing group support
- offering regular follow up (weekly)
- negotiating changes in lifestyle habits, focusing on boosting physical activity and moving eating patterns in a healthier direction
- using behavioural change techniques to inculcate improvements in lifestyle habits.

2.3 “But Weight Watchers is right” (Will Hutton, *The Observer*, 2 December 2007): “The ritual of the weekly weigh-in, the plotting of your weight reduction on a chart, the half-hour lecture and the sharing of the last week’s trials and tribulations form cornerstones in the programme . . . I tried sporadically to slim before Weight Watchers, but it did not work . . . I have lost 13 pounds and feel better than I have for 20 years, but it is a fragile achievement. In today’s environment, most weight loss is quickly reversed. We need change and we need it urgently”.

2.4 Research studies show that Weight Watchers is effective in helping people achieve and maintain long term weight loss at 2 and 5 years (Lowe MR *et al* {2001/2004}; Heshka S *et al* {2003}).

2.5 In summary Weight Watchers is not a diet, it is a way of life. The NICE guidance on obesity (2006) noted Weight Watchers as the only commercial slimming programme with good quality data underpinning its effectiveness.

3. REFERRAL SCHEMES MAKE WEIGHT WATCHERS MORE ACCESSIBLE TO VULNERABLE GROUPS

3.1 Weight Watchers runs meetings in a variety of areas, including deprived areas, and an initial analysis of meeting distribution in deprived postcode areas confirms this. However, over the last four years Weight Watchers has been working with the NHS to develop and run a Referral Scheme which enables:

- health professionals (mostly GPs and Practice Nurses) to refer suitable patients to a 12 week course of Weight Watchers meetings
- patients to attend at no or nominal cost to themselves.

3.2 The Referral Scheme is heavily subsidised by Weight Watchers and is one of the company's "not for profit" initiatives developed to enhance its contribution to alleviating the obesity crisis.

3.3 The Referral Scheme has been rigorously evaluated to ensure that the service is appropriate for the NHS (particularly patients), and to quantify weight loss outcomes. Weight Watchers has collected data on weight change from 1058 referral courses in 20 Primary Care Trusts and 1 workplace, and this data was independently analysed by MRC Human Nutrition Research in Cambridge. The principal outcomes included:

- 55% of patients attended every meeting for 12 weeks and lost 5.2 kg on average over this period
- more than half of these (54%) achieved a weight loss equal to or greater than 5% of their initial body weight (a level associated with appreciable decrease in disease risk) (Poulter and Hunt, 2007).

3.4 An economic analysis has been undertaken by the Health Economics Consortium at York University to assess the relative costs and benefits (in health terms) of Weight Watchers' methods. The study suggests that Weight Watchers is a cost effective intervention to help prevent and manage obesity. The cost effectiveness ratio generated by the economic model used (£1,022) is towards the lower end of the range of those for other interventions (Trueman and Flack, 2006). The authors concluded that referral to Weight Watchers is more cost effective than "doing nothing", and that the economic burden of obesity is continuing to escalate.

3.5 Case studies illustrating Weight Watchers' referral outreach to deprived communities and elderly patients are appended (Appendices 1 and 2).

4. TAILORING WEIGHT WATCHERS FOR SOUTH ASIAN COMMUNITIES

4.1 Analysis of Weight Watchers' own meeting database has revealed that meetings do take place in ethnically diverse areas, but anecdotal evidence suggests that membership from ethnic groups is sparse. For these reasons Weight Watchers has identified ethnic minorities as a strategic priority for 2008 and beyond.

4.2 Specifically, Weight Watchers is working in partnership with Bristol University to conduct evaluative research to examine how to tailor Weight Watchers methods to overweight and obese South Asian women in Bristol. The research is two pronged and sets out to:

- develop culturally appropriate interventions, and
- test whether these are effective in helping South Asian women lose weight and change their habits over a 12 week period.

4.3 The research is due to report in 2008 and will inform the future development of Weight Watchers' offerings to South Asian communities.

January 2008

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Appendix 1

CASE STUDY—THE WIDNES STORY

Weight Watchers initially worked in partnership with Halton General Hospital to offer a 10-week course free of charge to overweight patients in a very deprived area. The project was specially funded from the Single Regeneration Budget. A dedicated Weight Watchers meeting was set up at the Castlefields Community Centre, and the Weight Watchers leader was accompanied to meetings by a PCT-funded “minder” to enhance the feeling of safety for all who attended the sessions. The project started in January 2003 and since then two further meetings have been set up targeted at neighbouring deprived localities. In addition, Weight Watchers members now have access to a Food Co-op, “Cook and Taste sessions” run by a community food worker, and exercise sessions including a Health Walks scheme.

In the first year, 59 patients signed up for Weight Watchers and this has increased to 93 patients over a 15 month period. To evaluate the scheme questionnaires completed by 53 participants were analysed together with weight loss data.

What sort of patients attended?

- 78% of attendees were on income benefit and 79% unemployed.
- 60% had health problems (e.g. high blood pressure).

How did participants rate the scheme?

- Overall patients were very positive about their Weight Watchers experience.
- 55% said they wouldn’t have attended Weight Watchers if it wasn’t funded by the NHS.
- 80% of participants said that the weight loss achieved through Weight Watchers had improved their self esteem.

How many completed the 10 week course?

- 64% completed the 10 week course.

Did they lose weight?

- 31% of the total sample achieved a 5% or more weight loss.
- Of those who completed 10 weeks, 49% lost 5% or more.
- The average starting weight was 101 kg and the mean weight loss was 3.2 kg.

Appendix 2

THE WEIGHT WATCHERS REFERRAL SCHEME

*Guidance for Health Service Managers*¹⁸⁰

Memorandum by the Faculty of Public Health of the Royal College of Physicians of the United Kingdom
(HI 21)

HEALTH INEQUALITIES

ABOUT THE FACULTY OF PUBLIC HEALTH

The Faculty of Public Health (FPH) is the leading professional body for public health specialists in the UK. It aims to promote and protect the health of the population, and improve health services, by maintaining professional and educational standards, advocating on key public health issues, and providing practical information and guidance for public health professionals.

¹⁸⁰ Not printed, refer to organisation.

INTRODUCTION

1. The FPH welcomes the opportunity to contribute to the Health Select Committee's review of health inequalities—an issue which is at the heart of public health and underpins its central principle of improving population health.

2. We believe this is the right time to be undertaking this enquiry. Successive Wanless reports have repeatedly pointed out the disproportionate burden of chronic disease among disadvantaged people and the need for more “upstream” preventive approaches and improved access to these services, particularly for the more vulnerable groups and individuals in our society. Recent policy statements from government have emphasised the need to tackle health inequalities and to put the issue high on the agenda. However, we believe the reality lags a long way behind the rhetoric. There needs to be a very substantial shift of resources into upstream approaches to provide the all-embracing and specially tailored services required in the community. There also needs to be far more effective partnership-working between the NHS, local government, the voluntary sector and the public.

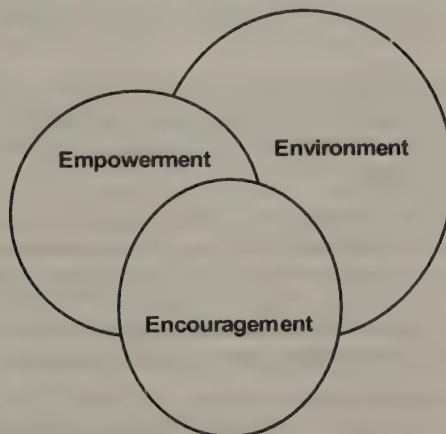
3. Reducing health inequalities is a fundamental driver of the public health function—some would say the fundamental driver. Conversely, public health skills and expertise are crucial to a proper understanding of the issues behind health inequalities, analysing the health needs of disadvantaged people, and planning and delivering services to meet those needs. We have therefore confined our comments to the public health (as opposed to the more clinical) aspects of the issue.

4. The public health function operates across three mains “domains”:

- *Health improvement* (which is about promoting healthy lifestyles and healthy environments and encompasses issues of inequalities and the wider social determinants of health such as employment, education, community etc.)
- *Service improvement* (which is about planning, commissioning and evaluation of services and interventions to ensure they are effective, of high-quality and safe. Inequalities issues of appropriateness and accessibility are crucial here).
- *Health protection* (including immunisation and vaccination, screening, injury prevention, control of infectious diseases, emergency planning, etc. Again there are many inequalities issues in this domain, eg with disadvantaged people missing out on vaccinations or screening opportunities, and being more susceptible to accidents and injuries).

5. The NHS plays a key part in all three public health domains. Planners, commissioners and providers of NHS services need to recognise that health inequalities are heavily influenced by social inequalities and that effective action to tackle inequalities must encompass insight into and understanding of each of the three domains. This requires appropriate education and training of key staff, from the frontline to the backroom, in basic public health skills, and a fully developed specialist public health workforce to support them.

6. Key to any strategy to reduce health inequalities is to engage and empower those who are most at risk of experiencing them. One model for achieving this is the “*Three Es Model for Lifestyle Change*” (see Fig 1).



Encouragement: simple exhortation – adverts, leaflets, one-to-one advice, campaigns etc. Encouragement is a useful trigger for people to make healthy choices, but unlikely to be effective or sustainable across the whole population without....

Empowerment: education and personal/community development – the development of knowledge, life-skills and confidence, to enable people to make healthy choices. Its effectiveness can be greatly boosted by...

Environment: making changes to the social, cultural, economic and physical surroundings within which people live, work and play – to help make the healthy choices the easy choices.

7. What the “Three Es Model” clearly demonstrates is that reducing inequalities is not solely the responsibility of one organisation or professional group, and that it is critical that those with a vested interest in the public’s health, such as the NHS, government, local authorities and the third sector, work across professional boundaries to provide an equitable, equality-driven health service. Public health teams therefore have a critical role to play in working across and joining up these professional boundaries.

8. However, sustained reductions in health inequalities can only be achieved if there is sufficient resource to deliver and maintain programmes aimed at reducing both social and health inequalities. *Choosing Health* in England set out the government’s commitment—including financial—to tackling the major causes and consequences of inequalities. Yet the financial crisis which engulfed the NHS in 2006–07 has seen the money promised to the NHS under *Choosing Health* subsumed into general PCT budgets. The FPH believes that substantial funding for upstream public health programmes, whether delivered through primary care, community services, social care, the voluntary sector, mental health services or another provider, must be re-instated as a matter of urgency. This must encompass programmes to tackle inequities and inequalities across maternal and child health, young people’s health and older people’s health, with particular emphasis on improving nutrition, reducing smoking prevalence, preventing obesity, improving sexual and mental health, and tackling alcohol misuse.

9. *Choosing Health* set an ambitious agenda for improving public health. Yet the most recent reconfiguration of PCTs and SHAs has resulted in a shift in focus away from the health inequalities agenda and has led to a loss of valuable senior level public health expertise and a reduction in recruitment. Our latest survey of the public health workforce, conducted last autumn, shows that the number of public health consultants/specialists across the UK has declined still further to 939—a fall of 30% since 2003. If government is committed to reducing health inequalities, then it must (in addition to protecting the expertise currently in place) support the development of a well trained and adequately resourced specialist public health workforce.

10. Whilst the FPH welcomes the recent announcement by the Prime Minister to prioritise prevention of ill health through the implementation of population screening programmes for diseases such as coronary heart disease and diabetes, it is critical that any such interventions do not exacerbate health inequalities. Government must ensure that any such screening programmes are both evidence-based and effectively targeted at those groups most at risk but which are least likely to uptake interventions or use health services.

11. The FPH is committed to supporting its members and to working with other organisations to prioritise action on reducing health inequalities, through lobbying for health protecting legislation (such as smokefree public places and workplaces) and providing practical guidance on tackling issues at local level (eg toolkits such as *Lightening the Load: tackling overweight and obesity*).

12. The FPH is also working with the Department of Health in England to build on existing good practice. On 6 February a joint workshop is being held to bring together acknowledged leaders in reduction of health inequalities at local level to share good practice and identify gaps where more needs to be done.

RESPONSES TO QUESTIONS RAISED BY THE REVIEW

Question 1: *To what extent can the NHS contribute to reducing health inequalities, given that many of the causes of inequalities relate to other policy areas e.g. taxation, employment, housing, education and local government?*

13. We welcome the Committee’s recognition of the great importance of other policy areas in determining health and health inequalities. However, as outlined above, the NHS has a crucially important part to play in reducing health inequalities in all its services and settings, from health promotion at one end of the spectrum to palliative care at the other.

14. The NHS is a key partner in strategic approaches to tackle this issue at national, regional and local level. Universal services must be sufficiently flexible to accommodate the wide range of needs of their populations, including the most disadvantaged; and specialised services which cater specifically for particular subgroups of the population must be sufficiently well resourced to have a real impact. Comprehensive service reviews, such as the Next Stage Review of Lord Darzi in England, must ensure that they fully address the challenge of effectively tackling health inequalities.

15. This all-embracing comprehensive approach does not come cheap. Health promotion and preventive efforts in the community, many of which are channelled through primary care, require a massive investment to be effective. This requires a sea-change in the flow of funding so that the shift in the balance of NHS resources between primary/community-based services on the one hand and acute services on the other is significant and tangible. Too often the government rhetoric is there, but the reality fails to materialise. Despite all the promises, we have yet to see any real transfer of resources from the acute sector into community-based services, and indeed, important underpinning and support functions, such as public health specialist teams, have had to endure major cuts and disruptions, further weakening their ability to provide effective advice, analysis and leadership.

16. Reducing inequalities is a long game. It requires sustained investment in the appropriate services, aimed at the most vulnerable people and those in greatest need, tailored to their particular requirements, and made available, accessible and affordable to them. The right services, offered in the right way, to the right people, in the right places and the right times. Deciding what is “right” in each of these parameters requires considerable expertise and analytical skill. Such expertise is embodied in public health specialists, who are comprehensively trained in all the key skills necessary to truly understand the health needs of their population and help plan and commission services in a way that can reduce inequalities. World-class commissioning will become second-class commissioning if it does not effectively address issues of inequity and inequality. If we are to be effective in our efforts, it is crucial that specialist public health skills and expertise are brought to bear in planning and commissioning. For this to happen the recent fall in funding and staffing levels for the public health function at all levels of the NHS must be reversed as a matter of urgency.

17. The NHS can make an important contribution to reducing health inequalities through:

- ensuring provision of an equitable and equality-driving health service by improving accessibility of services, providing locally available services (ie. eliminating the postcode lottery of services), and improving care pathways to provide a seamless service—including through working with other sectors such as local authorities and the third sector. Critical to this is a thorough and comprehensive understanding of the health and wellbeing needs and aspirations of the population served. This requires in-depth analysis of the many different communities and cultures within the population with particular regard to the needs, demands and use of health services;
- fully embracing the patient-centred approach with an emphasis on understanding and serving each individual’s needs and aspirations. This requires fit-for-purpose communication skills at all levels and in all settings of the service. Comprehensive equality and diversity training and support for all staff is critical;
- identifying those most at risk of health inequalities eg. those suffering/at risk of fuel poverty and acting as a link with other services to reduce risks;
- partnership working—such as the importance of joint planning and commissioning across PCTs, local authorities and the third sector, and in delivering joint strategies such as the “Three Es Model” and other relevant programmes. In this, the specialist public health professional has a crucial role to play in spanning NHS and local government agendas;
- collating valuable data on health issues (and tapping into public health expertise in this area) such as A&E admissions for alcohol-related injuries and sharing this with other relevant organisations to provide a clear picture of the scale of an issue (public health teams have a critical role to play in data collection and synthesis);
- joint delivery of shared targets provided it is adequately resourced—and leadership and support is provided by a joined-up central government approach to support and sustain local initiatives;
- using its vast purchasing power to contribute to the development of sustainable communities and boosting the local economy by procuring only local goods and services (e.g. locally produced food)—and which could also contribute to reducing carbon emissions.

Question 2: What is the distribution and quality of GP services and their influence on health inequalities, including how the Quality and Outcomes Framework and Practice-based Commissioning might be used to improve the quality and distribution of GP services to reduce health inequalities?

18. Despite the increased investment in primary care services, there are still far too many examples of Dr Julian Tudor Hart’s infamous “inverse care law”—the poorest quality care tends to be found in those areas most in need of the highest quality care. Increasing the availability and accessibility of high quality primary care in disadvantaged areas must underpin any serious attempt to tackle health inequalities. This may require increased financial incentives to providers of services in such areas, including capital and revenue incentives. There tends to be a problem of high staff turnover in disadvantaged areas and difficulties in recruitment and retention. This can be tackled through improved staff training and reward schemes.

19. Specific issues to note concerning QOFs include:

- QOF is not designed to improve the distribution of GP services.
- QOF may not be supporting public health in general practice, and therefore may not help reduce health inequalities.
- QOF is not as comprehensive a source of information as its proponents suggest, as there are no breakdowns by age, sex, ethnicity, or socio-economic factors.
- As with many such systems, perverse incentives can exist and QOF data can be manipulated by altering the numerator or the denominator. For example, better figures for control of hypertension can be obtained by not including on a disease register people whose blood pressure has been measured as high but not followed up recently.
- In theory, QOF can be used to improve the quality of services but in practice this is difficult.

- It requires targets to be met to trigger payments, but these targets need to be achievable but not so easy to achieve in many practices that no change is required, and yet not so difficult to achieve in other practices that there is no incentive to make progress because the targets will never be hit. There tends to be an assumption that practices' performance reflects the quality of the organisation and the healthcare professionals. While these are important, patient / population factors are also crucial. GPs working in an area with well-motivated middle-class patients will need to do less to achieve the same proportionate targets as those working in areas with very high patient turnover, fewer personal resources, and multiple problems to address.
- The targets need to be beneficial in terms of improving health and reducing health inequalities. Although the 2003 GP contract focused on the health of the practice population, QOF points are geared towards biomedical measurement and delivery of risk-factor related healthcare, particularly prescribing additional medication, without acknowledgment of holistic care of individuals in primary care.
- There sometimes needs to be an explicit trade-off between improving overall health and reducing health inequalities. QOF focuses on the former and can therefore worsen the latter.

20. However, there is some encouraging research evidence (summarised in the written submission to the Committee by Millett and Majeed) that at both practice and individual level, QOF has contributed to reductions in inequalities in management of people with chronic diseases:

- There were small differences in QOF performance between practices working in deprived and affluent areas in the first year of the contract.
- These differences appear to have narrowed in the second year of the contract.
- Studies using individual patient data suggest that there were marked age, gender and ethnic group inequalities in the quality of care being delivered before the introduction of QOF. Some of these inequalities have been partially attenuated afterwards.

Question 3: How effective are public health services at reducing inequalities by targeting key causes such as smoking and obesity, including whether some public health interventions may lead to increases in health inequalities; and which interventions are most cost-effective?

21. It is important to recognise that there are immediate causes of ill-health and health inequalities, such as smoking, obesity and alcohol misuse, but that there are also broader social determinants which affect these risk factors. For example, smoking prevalence has a clear social class gradient. As previously stated, it is clear that in order to reduce health inequalities, action is needed to reduce inequalities in general—which requires leadership from government, but also a joined-up approach across the various sectors.

22. Although there has been a reduction in inequalities in cancer and cardiovascular mortality, this has not been matched by reductions in infant mortality or in increases in life expectancy:

- Infant mortality: The inequality gap in the infant mortality rate has reduced for the second consecutive period, though not yet by a sufficient amount to meet the target, based on the trend since the current socio economic classifications were introduced in 2001.
- Life expectancy at birth: The inequality gaps in male and female life expectancy at birth have both increased since the baseline. If current trends continue, the target would not be met.

23. However, much can be done by targeting immediate causes. For example, smoking accounts for at least half of all inequalities in premature mortality. Of 1,000 20-year-olds who smoke 20 a day, one will commit suicide or be murdered, six will be killed in a road traffic collision, and 500 will die prematurely because of their smoking. These deaths occur mainly from cardiovascular disease (particularly heart disease and stroke), from a range of cancers, and from respiratory diseases (particularly chronic obstructive pulmonary disease)—all of which show strong social class gradients and make substantial contributions to health inequalities. Those dying prematurely from smoking come disproportionately from more disadvantaged groups. There is a heavy social class gradient in smoking prevalence, tobacco consumption, and age of starting smoking by social class, education, or income, each of which contributes to the very large social gradient in tobacco-related death, disease, and disability.

24. Smoking can be considered both a symptom of and, paradoxically, a cause of, poverty. The latter is explained by its addictiveness, such that considerable amounts of money—and a higher proportion of lower incomes—is spent buying tobacco, and its contribution to ill-health at a much younger age than would otherwise have occurred in that individual, therefore also reducing the ability to work and earn money.

25. A comprehensive tobacco control strategy would have a large impact on health inequalities in the short, medium and longer term.

26. With reference to obesity, the Committee will no doubt read the recent Foresight Report (2007) which stresses the “passive obesity” encouraged by the environment in which most people live. From the point of view of reducing health inequalities, this means that environmental change should be given a high priority. Measures which simply encourage healthy lifestyles tend to be more widely adopted by those better able to make healthier choices, and in this way are likely to increase inequalities. Nevertheless the average population level of the relevant indicator is increased.

Question 4: *Are specific interventions designed to tackle health inequalities, such as Sure Start and Health Action Zones, effective and cost-effective?*

27. The most important policies to reduce inequalities are those which affect the social determinants of health. Sure Start and Health Action Zones can make a contribution to reducing inequalities, although in a more modest way.

28. NHS smoking cessation, which were originally piloted in Health Action Zones, have now been shown to be both effective and cost-effective, particularly the broader NHS cessation services which have been shown to be effective in more disadvantaged populations.

29. The Cornwall and Isles of Scilly HAZ included a specific strand on reducing health inequalities. It was subject to independent audit, led by Prof Sheena Asthana and Dr Joyce Halliday of Plymouth University. See eg Halliday J, Asthana S. Policy at the Margins: Developing Community Capacity in a Rural Health Action Zone. *Area*. 2005;37(2):180–188.

30. HAZs were introduced when the incoming Labour government was constrained by its promise to stay within the overall financial limits set by the outgoing administration. This meant that most people in health inequality were outside HAZs.

31. The overall evaluation of HAZs was carried out by Bauld and Judge—see <http://eurpub.oxfordjournals.org/cgi/content/full/16/4/341?etoc>

Question 5: *How successful are NHS organisations at co-ordinating activities with other organisations, for example local authorities, education and housing providers, to tackle inequalities; and what incentives can be provided to ensure these organisations improve care?*

32. As noted above, the role of public health teams—particularly public health specialists such as directors of public health (DPH)—are crucial in working across professional boundaries and in joining up agendas. However, they need to be adequately resourced to deliver on this.

33. The recent reconfiguration of the NHS resulted in a lengthy period without recruitment for new staff, such as those ending training schemes, a reduction in training placements and increased job insecurity for those already in post. Fewer public health posts now exist—particularly at the specialist level. These changes have combined to result in a substantial loss of workforce capacity. Public health delivery requires stability, not only in terms of recruitment and retention, but to ensure a sufficient knowledge-base and adequate resource for delivery of sustainable health programmes—particularly at the local level—including forming partnerships with other local sector organisations.

34. One specific example of successful cross-sectoral working is the Heart of Mersey project which is a partnership between the local NHS PCTs and Local Authorities. It was launched in 2003 to help tackle the very high levels of CVD in Greater Merseyside, where the disease kills 30% more women and 20% more men than in most other parts of the country.

35. Cardiovascular disease (heart disease and stroke, CVD) makes a major contribution to premature deaths and health inequalities. 80% of CVD is preventable, mainly through reducing the major risk factors (like smoking, poor diet and inactivity) rather than through treatments when the disease has already struck.

36. The Heart of Mersey project was modelled on the internationally successful North Karelia Project in Finland and aims to add value to local initiatives and programmes to prevent coronary heart disease, and its risk factors, through integrated, evidence-based interventions, lobbying and advocacy.

Question 6: *How effective is the Department of Health in co-ordinating policy with other government departments, in order to meet its Public Service Agreement targets for reducing inequalities; and is Government likely to meet its Public Service Agreement targets in respect of health inequalities?*

37. While the Government persists in having an individual-focus to health and inequalities, there will be difficulties in meeting targets.

38. As described above, there are immediate causes of health inequalities and social determinants of these. Until all government departments are aware of and act upon their ability to influence these determinants of health, the Department of Health will continue to be regarded as the Department of the NHS, itself a misnomer for the National Illness Service.

39. Policies focussing on individuals are important, for example for supporting individual smokers who wish to stop smoking, but these need to be complementary to and not instead of population policies and interventions. There have been recent encouraging signs, such as the focus in the New Cancer Plan of broader tobacco control strategies and an acknowledgment that however effective the Smokefree legislation is that was implemented in July 2007, tobacco control will remain important as long as significant numbers of the population continue to smoke.

40. Obesity is increasing in prevalence and will lead to increasing risk of diabetes and therefore cardiovascular disease. Because of the inequalities in obesity prevalence, the subsequent health impacts will also lead to increased health inequalities. Exhorting individuals to take more exercise is less effective—and much less cost-effective—than changing the physical and cultural environment in which individuals make their decisions. Walking is more likely in areas with clean, uncluttered, well-lit pavements and parks; where traffic is absent or slower; where more people are walking; and where perceptions of safety are greater. This is one reason why the Sustrans traffic-free walking and cycling routes have been so successful in encouraging travel by these modes, with evidence of car journeys replaced by walking and cycling, and of encouraging people (particularly women, who are on average less physically active) to take up cycling who have not cycled before, or not since childhood.

41. One specific example where Public Service Agreement targets are important in reducing health inequalities is the HMRC PSA target for reducing smuggling. It is very important that a new PSA target is agreed as the current HMRC target ceases at the end of this year.

GENERAL COMMENT

42. One critically important issue which has gained prominence and which will impact on health, and increase health inequalities, in the most fundamental way is climate change. FPH believes that climate change has become one of the most important public health challenges of this century. It threatens the basic elements of our existence—access to water, food production and land use. It could lead to exacerbated inequalities through displacement of large numbers of people, loss of entitlement and access to goods and services, and increased food and fuel insecurity. The FPH is publishing a report on the impact of climate change on health in January 2008.

43. The FPH would also like to highlight, in brief, those areas which require urgent action to reduce inequalities including:

- mental health
- alcohol
- sexual health
- fuel poverty

44. The Faculty of Public Health would be most willing to give oral evidence to the review should this be desired.

January 2008

Memorandum by Roche Diagnostics (HI 22)

HEALTH INEQUALITIES

1. EXECUTIVE SUMMARY

1.1 Roche Diagnostics welcomes the Health Committee's inquiry into health inequalities. We would like to take the opportunity provided by the inquiry's call for evidence to highlight the need to consider sexual health services as part of the broader strategy for tackling health inequalities.

1.2 The role of sexual ill-health in contributing to health inequalities has historically been overlooked, in part perhaps because it does not impact directly on the Government's two Public Services Agreement targets to reduce the gap in life expectancy and infant mortality between the general population and the spearhead local authorities.

1.3 This is unfortunate, because the lessons learnt from the actions taken to tackle sexual ill-health (which, by necessity, must include action across local government, taxation policy and education) can be applied more widely across government in support of other health inequalities strategies.

1.4 However, tackling sexual ill-health must of course also include action from the health service itself. The Committee may wish to examine the possibility of using financial incentives to prioritise the delivery of sexual health services in more deprived areas, and—in particular—their role in enhancing delivery of the National Chlamydia Screening Programme.

2. SEXUAL HEALTH INEQUALITIES

2.1 An earlier inquiry by the Committee noted that, “the inequalities in health repeat themselves in sexual health”, and that the burden of sexual ill-health is borne disproportionately by women, gay men, teenagers, young adults and black and ethnic minorities.¹⁸¹ A recent inquiry by the Healthcare Commission also noted that, “good sexual health services are vital in inspiring public health and tackling health inequalities”.¹⁸²

2.2 However, despite this, sexual health is often overlooked in Government policy aimed at tackling health inequalities. The Department of Health’s original strategy, *Tackling health inequalities: a programme for action*, made only passing reference to sexual health (in the context of children’s policy)¹⁸³, while its latest *Policy Update* does not mention sexual health at all.¹⁸⁴

3. THE BURDEN OF CHLAMYDIA

3.1 Chlamydia is the most common sexually-transmitted infection, with 99,230 newly diagnosed cases in 2006—an increase of 276% from its 1993 low of 26,381 cases.¹⁸⁵ Chlamydia is a simple condition to diagnose and treat, yet often occurs in people asymptotically. Where it is not identified and treated, it can cause both male and female infertility, and is one of the leading factors contributing to ectopic pregnancies.

3.2 The burden of Chlamydia and its effects are borne disproportionately by certain groups: it is significantly more prevalent among men who have sex with men, young people and sex workers¹⁸⁶, as well as amongst African Caribbean populations.¹⁸⁷ In addition, the Health Committee has noted that, “there is some evidence to suggest that Chlamydia infection rates are associated with deprivation”.¹⁸⁸

4. PROGRESS IN TACKLING CHLAMYDIA

4.1 Roche Diagnostics’ interest in Chlamydia has been long-standing: we developed the first high-accuracy test for Chlamydia used as standard in clinical practice; and we have worked on a variety of projects in recent years seeking ways to identify infected people in hard-to-reach groups and have them treated. The National Chlamydia Screening Programme (NCSP)—an initiative by the Government and the Health Protection Agency which is to be much welcomed—has adopted some of the strategies which the work we have supported has identified.

4.2 We believe that the NCSP must form a crucial element of any strategy to tackle sexual health inequalities and health inequalities more generally, and would ask the Committee to consider the ways in which its implementation could be further supported. Primary Care Trusts (PCTs) have been asked to screen 15% of under 25s for Chlamydia infection by March 2008, yet the latest data—for the half-year to September 2007—suggest that just 1.7% of this target population has been screened thus far—and that in some areas screening has not yet commenced at all.¹⁸⁹

5. TACKLING SEXUAL HEALTH INEQUALITIES IN PRIMARY CARE

5.1 There is great potential for tackling sexual ill-health amongst young adults in primary care, since each year over 3 in 5 men and over 3 in 4 women aged 16–24 attend their GP practice.¹⁹⁰ However, evidence suggests that tackling sexual ill-health in primary care must be encouraged by the use of financial incentives.

5.2 Financial incentives for, for example, Chlamydia screening were used in the original NCSP pilots, with GPs offered £25 for the first 600 tests and £10 thereafter¹⁹¹, but—as the British Journal of General Practice has found—“since the financial incentive was discontinued, the proportion of tests done in general practice dropped significantly”.¹⁹² A recent survey by Pulse magazine found that just one in ten PCTs are offering any financial incentives to GPs to undertake Chlamydia screening¹⁹³, but Lambeth PCT—which is offering financial incentives—now has rates of screening of the target population well above the national average.¹⁹⁴

¹⁸¹ Health Committee, *Sexual Health*, 11 June 2003.

¹⁸² Healthcare Commission, *Performing better?*, June 2007.

¹⁸³ Department of Health, *Tackling health inequalities: a programme for action*, 2 July 2003.

¹⁸⁴ Department of Health, *Tackling health inequalities: policy update for 2010 national target*, 14 December 2007.

¹⁸⁵ *Hansard*, 2 October 2006, Col. 2529W; and *Hansard*, 15 October 2007, Col. 931W.

¹⁸⁶ Mayor of London, *Reducing health inequalities—issues for London and priorities for action*, August 2007.

¹⁸⁷ King’s College, London, Centre for Caribbean Health, 7 December 2006; available here: <http://www.kcl.ac.uk/schools/medicine/learning/international/caribbean/sexualhealth.html>

¹⁸⁸ Health Committee, *Sexual Health*, 11 June 2003.

¹⁸⁹ Health Protection Agency, *National Chlamydia Screening Programme: NHS Local Delivery Plan data monitoring*, 16 November 2007.

¹⁹⁰ *British Journal of General Practice*, *Opportunistic and systematic screening for Chlamydia: a study of consultations by young adults in general practice*, 2006.

¹⁹¹ *Journal of Sexually Transmitted Infection*, *Opportunistic screening for genital Chlamydial infection: Acceptability of urine testing in primary and secondary healthcare settings*, 2003.

¹⁹² *British Journal of General Practice*, *With appropriate incentives, general practice can improve the coverage of the National Chlamydia Screening Programme*, November 2006.

¹⁹³ *Pulse*, *Trusts to miss Chlamydia deadline*, 23 February 2007.

¹⁹⁴ *Healthcare Republic*, *General practice incentives for Chlamydia screening*, 1 May 2007.

5.3 The potential for incorporating Chlamydia in the GP contract was acknowledged by the Health Select Committee in 2005. In evidence to the Committee, the Deputy Division Head for Sexual Health at the Department of Health explained that, “certainly Chlamydia is one of the issues that we particularly recognise as being relevant to [the GP contract]”.¹⁹⁵

5.4 The Committee may wish to revisit this finding, and consider whether Chlamydia screening can be encouraged either through the incorporation of indicators of sexual health in the Quality and Outcomes Framework, or by defining Chlamydia as a national Directed Enhanced Service.

6. CONCLUDING REMARKS

6.1 The burden of sexual ill-health falls disproportionately on certain populations, and contributes to the wider burden of health inequalities. Any effective strategy for tackling health inequalities must, therefore, consider how sexual health services can be made more accessible to hard-to-reach groups.

6.2 The potential for tackling sexual ill-health in primary care has yet to be fully harnessed, despite the existence of mechanisms—such as those in the GP contract—which can be deployed to encourage it.

January 2008

Memorandum by the Men’s Health Forum (HI 23)

THE CONTRIBUTION OF THE NHS TO REDUCING HEALTH INEQUALITIES

1. EXECUTIVE SUMMARY

1.1 Gender is a crucial dimension of health inequalities that must be considered alongside social class, ethnicity, age, sexuality and other key factors. Although there are clearly many areas of health where women are disadvantaged, it is men who in general suffer the worst outcomes. It is vital, therefore, that any inquiry into health inequalities addresses gender issues and men’s health in particular.

1.2 Average male life expectancy at birth in the UK is just under 77 years, according to ONS figures. The female equivalent is just above 81 years. However, men’s life expectancy is more severely affected by deprivation than that of women.

1.3 A baby boy born in Kensington and Chelsea has a life expectancy of 83.1 years, the longest in the UK. In Manchester, the lowest in England, it is just 73 years and in Glasgow, the lowest in the UK, it is just 70.5 years. A women’s life expectancy at birth is also highest in Kensington and Chelsea and lowest in the UK in Glasgow at 87.2 and 77 years respectively. Liverpool has the lowest female life expectancy in England at 78.3 years.

1.4 Looking at social class rather than geography, ONS figures show a male professional can expect to live to 80 years, more than seven years longer than a man in an unskilled manual job (72.7 years).

1.5 Three quarters of all suicides are by men.

1.6 67% of men are overweight or obese as are 58% of women.

1.7 Men are almost twice as likely to develop and to die from the ten most common cancers that affect both sexes.

1.8 Men are more likely than women to take risks with their health—they are, for example, more likely to smoke, to drink alcohol at above recommended levels, to expose themselves to the sun without protection, to eat a poorer diet and to drive dangerously.

1.9 Men generally make poorer use of primary care services than women, including GP, pharmacy, walk-in clinic and dental services. It is the widespread experience of health practitioners that this contributes to delayed diagnosis and worse outcomes.

1.10 The projects that do exist to tackle male health inequalities are often isolated and not an integrated part of the work of primary care trusts. Successful action to prevent or tackle male health problems has often been the result of the NHS and others, mainly local authorities or employers, working together.

1.11 Full implementation of the Equality Act 2006’s public sector gender duties requires action to address inequalities in outcomes. The Men’s Health Forum believes that the introduction of gender-sensitive health services is crucial—services should be designed and promoted taking into account the different health needs, attitudes and behaviours of men and women. But compliance with the Equality Act has so far been poor with many PCTs failing to meet the deadline for publishing Gender Equality Schemes. The content of most of the Schemes that have been published also fails to meet the requirements of the Code of Practice.

¹⁹⁵ Health Select Committee, *New developments in sexual health and HIV/AIDS policy*, 20 March 2005.

2. INTRODUCTION

2.1 The Men's Health Forum (the Forum) is the leading charity working with health and other professionals to improve the health of boys and men in England and Wales. Amongst other things, the Forum is involved in:

- Research and policy development;
- Professional training;
- Providing information services;
- Stimulating professional and public debate;
- Working with MPs and Government (in particular, the Forum provides the secretariat for the All-Party Parliamentary Group for Men's Health);
- Developing innovative and imaginative projects;
- Collaborating with the widest possible range of interested organisations and individuals;
- Organising the annual National Men's Health Week.

2.2 The Forum exists because, to put it simply, male health is much poorer than it need be. Average male life expectancy, although rising, is still under 77 years and, in disadvantaged social groups and communities, it is as low as 70 years. The highest in the UK is 83.1 years in Kensington and Chelsea; the lowest in England is 73 years, in Manchester. A women's life expectancy at birth is also highest in Kensington and Chelsea and lowest in the UK in Glasgow at 87.2 and 77 years respectively. Liverpool has the lowest female life expectancy in England at 78.3 years. Average female life expectancy at birth is now 81.1 years.

2.3 Evidence suggests that one of the most significant causes of poor male health is the health-related behaviour of men and boys. Many men have unhealthy diets, smoke, have unsafe levels of sun exposure, drink alcohol at above recommended levels, drive dangerously and delay seeking help with health problems. But while men are currently far from "fully engaged" in their own health it is equally true that health services are far from "fully engaged" with men. There is still a limited understanding of how to develop the kind of services that will impact on male health effectively.

2.4 The extent to which the NHS can contribute to reducing health inequalities, given that many of the causes of inequalities relate to other policy areas eg taxation, employment, housing, education and local government.

2.5 Men's health is affected by a broad range of factors including poor working conditions, unemployment and low levels of educational attainment. There is no doubt that action is needed across all of these areas if men's health is to be improved. However, the NHS can, on its own, take action that would improve men's health. It can also collaborate with, and lead, a range of other organisations, not least local government, on joint action.

2.6 One key area where the NHS could make a difference to men's health on its own is by improving access to health services. It is well-established that men generally make poorer use than women of GP, pharmacy, Walk-In Centre and dental services. GP opening hours is one critical issue but, even more importantly, action needs to be taken to increase men's knowledge of the range of available health services and how to use them; the services themselves also need to do more to present themselves as attractive and relevant to men. There is increasing evidence that outreach services located in "male-friendly" venues—sports stadia, workplaces, working men's clubs, even pubs—can be effective.

2.7 There is evidence that a higher proportion of men use of Walk-In Centres than GP services—probably because they are much easier to access—but much more could be done to promote their availability. Pharmacy services are significantly under-used by men and it is hoped that a study, currently being undertaken by the Men's Health Forum for the Department of Health and other partners, will suggest how this might be changed.

3. THE DISTRIBUTION AND QUALITY OF GP SERVICES AND THEIR INFLUENCE ON HEALTH INEQUALITIES, INCLUDING HOW THE QUALITY AND OUTCOMES FRAMEWORK AND PRACTICE-BASED COMMISSIONING MIGHT BE USED TO IMPROVE THE QUALITY AND DISTRIBUTION OF GP SERVICES TO REDUCE HEALTH INEQUALITIES.

3.1 Men are generally reluctant users of traditional primary care, particularly GP services. Men's reluctance to seek professional advice is now widely-considered to be a significant contributory factor to their poor health outcomes. For example, fewer men than women are diagnosed with malignant melanoma but more men than women are killed by the condition. The most plausible explanation for this is late diagnosis due to late patient presentation.

3.2 A survey of men by the Men's Health Forum found high levels of consistency in responses to open questions about their views of GPs services. Aside from the opening hours of surgeries, men were concerned about the distance from work to the GP, GPs often running late and the total time involved in making an appointment. Whilst these concerns are not of course limited to men, despite significant changes in working patterns they will may impact on men disproportionately because they are still much more likely to work full time. Many also had concerns about the need to discuss their health problems with a receptionist to get

an appointment and some GPs were perceived to be awkward or condescending. There was also a widespread perception among men that the GP environment and services are more sympathetic to the needs of women and children.

3.3 The Men's Health Forum considers that, as a first step, there should be pilot studies which examine how GP services can be made more accessible to men. Indeed, this is actually now a legal requirement—before its recent abolition, the Equal Opportunities Commission stated that men's unequal access to primary care was an issue that had to be addressed under the terms of the Equality Act 2006.

3.4 The Men's Health Forum has been working with statutory organisations to support the implementation of the gender equality duty in the NHS, especially in primary care trusts. Many PCTs are still failing to meet the requirements of these duties established by the Equality Act 2006. A Men's Health Forum survey conducted three months after the regulations came into force showed that 40% of PCTs had yet to take the first step in compliance by publishing a Gender Equality Scheme setting out how they intended to improve health outcomes in their area.

3.5 The Forum expects that proper implementation of these rules would see PCTs use their commissioning contracts to require GPs (and other contractors) to improve the accessibility and suitability of services for men's needs.

3.6 The Quality and Outcomes Framework is potentially a useful mechanism for reducing gender inequalities but it is presently not used at all for that purpose. QOF should be reviewed to encourage GPs to tackle gender inequalities by awarding points on the basis of achieving equity between the sexes rather than simply increasing total numbers.

4. THE EFFECTIVENESS OF PUBLIC HEALTH SERVICES AT REDUCING INEQUALITIES BY TARGETING KEY CAUSES SUCH AS SMOKING AND OBESITY, INCLUDING WHETHER SOME PUBLIC HEALTH INTERVENTIONS MAY LEAD TO INCREASES IN HEALTH INEQUALITIES; AND WHICH INTERVENTIONS ARE MOST COST-EFFECTIVE.

4.1 Health services have, to date, overwhelmingly failed to address gender inequalities in health. There is also some evidence that public health interventions may inadvertently increase gender differences because women more likely to take them up; socially disadvantaged men are particularly unlikely to take them up.

4.2 Weight is a good example of this. Many men see weight as solely or primarily a women's issue. Men are less likely to recognise they are overweight, for example, and more likely to say they are not bothered if they are. This helps to explain why weight loss services that are in theory open equally to both sexes actually attract relatively few men. The Counterweight programme based in GP practices found only 26% of those participating were men. A joint NHS/commercial slimming club initiative found only 12% of those attending were men.

4.3 This does not mean, of course, that weight management services should not be offered; what it does mean is that a different approach is needed to ensure that men take part in proportion to their level of need.

4.4 The National Chlamydia Screening Programme should be congratulated for recognising that its approach was reaching an insufficient proportion of young men and that a more targeted programme was needed to reach them. In November, the NCSP launched a men's strategy which, if properly enacted locally, will result in much higher numbers of young men being screened and treated. The men's strategy in many ways provides a model for how other health services should develop their work with men.

4.5 The government has recently announced that it will introduce screening for abdominal aortic aneurysm targeted at older men. The Forum has been campaigning on this issue since 2004 and, in spring 2007, the National Screening Committee recommended it to the Department of Health. A screening programme has operated in Gloucestershire for a number of years and in some other countries. Despite welcoming the news that this screening will be introduced, the Forum is concerned that delays in its implementation could continue because, at the time of writing shortly after the announcement, there is no timetable for the screening programme to be delivered.

5. WHETHER THE GOVERNMENT IS LIKELY TO MEET ITS PUBLIC SERVICE AGREEMENT TARGETS IN RESPECT OF HEALTH INEQUALITIES.

5.1 From the Forum's perspective, the key factor in determining this will be the willingness of the Department of Health and other relevant government departments and agencies (including the new Equality and Human Rights Commission) to support, encourage and compel the local organisations they deal with, such as NHS PCTs and local authorities, to properly implement the public sector gender equality duty in order to improve men's health outcomes.

5.2 So far, as stated above, PCT compliance with this law is poor—many are not implementing systems to identify and not setting objectives to address gender inequalities in their area.

Memorandum by Smokefree North West (HI 24)

HEALTH INEQUALITIES

Smokefree North West is chaired by Dr Janet Atherton, Regional DPH Lead for Tobacco Control and coordinated by Andrea Crossfield, North West Regional Tobacco Policy Manager. It supports the work of three sub regional tobacco alliances. These are: Cheshire and Merseyside Tobacco Alliance; Greater Manchester Tobacco Alliance; SmokeFree Cumbria and Lancashire Partnership.

In addition to the Alliance Leads, a series of partners with a strategic focus on tobacco control issues take part in the SmokeFree North West Task Force. These include: Trading Standards North West; Heart of Mersey; North West Action on Smoking and Health (NW ASH); Roy Castle Lung Foundation; North West Centre for Public Health; North West Fire and Rescue Services; SmokeFree Liverpool.

It has recently published a scoping report, *Towards a Tobacco Free Future for the North West*, and is developing a three-year regional strategy with an over-arching focus on reducing tobacco-related health inequalities. Smoking is a major cause of ill health and preventable death and the links between smoking and cancer, heart disease and stroke are well-established. The health risks of exposure to second-hand tobacco smoke have also become widely recognised. Smoking prevalence and deprivation are closely linked and smoking is the greatest single cause of preventable inequalities in health in the North West.

The extent to which the NHS can contribute to reducing health inequalities, given that many of the causes of inequalities relate to other policy areas eg taxation, employment, housing, education and local government;

1. Within the North West, 18 out of the 24 PCTs link to spearhead local authorities, reflecting the higher rates of deprivation in this Region. In the North West, smoking accounts for over 14,000 deaths annually with one in five deaths in the region attributable to smoking. Moreover between approximately 900 and 1600 people die in the North West each year from cancer or ischemic heart disease because of exposure to second-hand smoke with the vast majority of these deaths due to exposure in the home. Smoking costs the NHS in the North West an estimated £194 million per annum. Over 3,000 premature deaths (of people aged under 75) could be prevented each year if the North West population did not smoke.

2. More than 1,300 people die from cancer each year in the North West who would not have died if this Region had the same death rates from cancer as England & Wales. About 60% of these excess deaths are due to lung cancer, underlining the importance of tobacco control. The relationship between high cancer rates and high levels of deprivation is even more striking for lung cancer than for all cancers combined due to the close association between smoking and deprivation.

3. The most deprived areas in the North West continue to have a greater rate of smoking attributable mortality than more affluent areas, particularly from cancers in men and women and respiratory disease in women. Male and female smoking prevalence amongst the population in the highest quintile for multiple deprivation were 33 per cent and 37 per cent respectively. This compares with male and female smoking prevalence rates of 14 per cent amongst the population in the lowest quintile. Equally, smoking prevalence for those within the routine and manual occupations was 31 per cent for men and 26 per cent for women. In contrast, smoking prevalence within managerial and professional occupations was 17 per cent for men and 16 per cent for women.

4. There is some evidence of a substantial reduction in smoking prevalence in the North West amongst women in the routine manual category—the data suggests that smoking amongst females in this category fell from 38 per cent in 2003 to 26 per cent in 2005.

5. Sub-regional and local authority level data provides evidence of divergent rates of smoking prevalence and, hence, smoking-related health inequalities. However, across the North West there are even wider disparities between localized areas. ASH has developed an online tool that provides information at ward level about deprivation and smoking prevalence. It shows that within the five most deprived wards in England—all of which are in the North West (Princess ward in Knowsley, Breckfield, Granby and Speke wards in Liverpool and Bradford ward in Manchester)—smoking prevalence is estimated at between 42 per cent and 52 per cent. It is no coincidence that these areas also map to a high incidence of early lung cancer deaths.

6. It is essential that the NHS work locally in partnership with Local Authorities, local communities, the community and voluntary sector and local businesses to deliver reductions in smoking prevalence in deprived groups. The Smokefree Legislation provided many opportunities for such joint working to target support to routine and manual group employers. Equally Local Area Agreements have been the source of much partnership work to reduce smoking prevalence in deprived communities across the North West. Local Authorities should be required to measure smoking rates as part of the Local Area Agreements since smoking is a key indicator for health inequalities

The distribution and quality of GP services and their influence on health inequalities, including how the Quality and Outcomes Framework and Practice-based Commissioning might be used to improve the quality and distribution of GP services to reduce health inequalities;

7. Primary care is a key setting for stop smoking interventions and an important source of referrals to stop smoking services. PCT Commissioners should ensure that all local GPs are aware of the need to ask their patients about their smoking status, provide brief advice and refer smokers who are motivated to quit to the local stop smoking service. Helping smokers to quit is a key part of the remit of all primary care staff and payments are already made to practices for this activity under the Quality Outcomes Framework (QOF).

8. Research recently published shows that the stop smoking services in England are reaching people in disadvantaged areas and that, to date, they have made a modest contribution towards reducing inequalities in smoking prevalence. However, the study also shows that in order to achieve Government targets, more innovative cessation interventions for the most addicted smokers will be required. Examples of successful innovation exist in Stop Smoking Services in Knowsley, Liverpool and Manchester which are consistently exceeding their 4 week quit targets and using social marketing approaches to ensure that they target their services at more deprived smokers. Specialist Stop Smoking Services should assist GP services in setting up sustainable systems for delivering brief intervention advice concerning smoking and PCTs must put in place commissioning arrangements to reflect this.

9. Assisting GP services in setting up sustainable systems for delivering brief intervention advice concerning smoking (prevention, cessation and protection from second-hand smoke) from all front line healthcare providers may be the single most clinically and cost effective preventive treatment in the NHS to improve a patient's quality of life, increase life years and reduce healthcare costs. It has been called the Gold Standard of preventive interventions and a clinical imperative. Because of the small investment of time required, failure to deliver brief advice could be considered poor clinical practice.

The effectiveness of public health services at reducing inequalities by targeting key causes such as smoking and obesity, including whether some public health interventions may lead to increases in health inequalities; and which interventions are most cost-effective;

10. A smoker who tries to quit with the NHS Stop Smoking Service and Champix/ NRT/ Zyban is up to four times as likely to succeed than by willpower alone.

11. Evidence-based stop smoking interventions represent excellent value for money as indicated by the following illustration:

Intervention	Outcome	NNT
Statins	Prevent one death over five years	107 (1)
Antihypertensive therapy	Prevent one stroke, MI, death over one year	700 (1)
Cervical cancer screening	Prevent one death over ten years	1140 (2)
GP brief advice to stop smoking < five minutes	Prevent one premature death*	80 (3)
Add pharmacological support	Prevent one premature death*	38–56 (4)
Add behavioural support	Prevent one premature death*	16–40 (5, 6)

Over half of all continuing smokers will die prematurely from a smoking-related disease. For every two long term quitters, one premature death is avoided (Doll and Peto) 1. Bandalier 2. Gates, Amer Fam Phys 2001 3. West 2006 4. Bandalier 2006. 5. Cochrane 2007 6. Anthosen Ann Inter Med 2005.

12. Unless there is sufficient investment in and targeting of stop smoking support at more deprived smokers there is a risk that reductions in smoking prevalence will be disproportionately seen in more affluent social groups.

Whether specific interventions designed to tackle health inequalities, such as Sure Start and Health Action Zones, have proved effective and cost-effective;

13. Across the North West there have been excellent examples of Sure Start and HAZ monies being used to support interventions to reduce smoking prevalence. For example, across Greater Manchester there have been collaborative projects with local Sure Starts to increase the number of smokefree homes and to encourage women to quit smoking during pregnancy and stay quit. Greater Manchester has seen a greater reduction in smoking prevalence in women in routine and manual groups in their 30s and 40s compared to the North West as a whole. An example of using HAZ monies to tackle smoking prevalence is provided by SmokeFree Liverpool which dedicated three years of substantial HAZ funding to an innovative tobacco control programme that specifically engaged its most deprived communities with the highest smoking rates resulting in a significant reduction in smoking prevalence of around 4% in those communities and city-wide between November 2005 and February 2007.

The success of NHS organisations at co-ordinating activities with other organisations, for example local authorities, education and housing providers, to tackle inequalities; and what incentives can be provided to ensure these organisations improve care;

14. Local Strategic Partnerships have facilitated collaborative work between the NHS locally and Local Authorities on the issue of smoking prevalence and health inequalities and joint Implementation Teams for Smokefree Legislation, as well as wider local Tobacco Control Alliances provide many examples of successful work in this area, engaging a wide range of partners. However much of the money invested in such collaborative projects (and used to fund vital coordination posts) has been short term funding eg, HAZ, NRF and LAA funding. This type of funding has been important in incentivising investment in tobacco control initiatives from mainstream funds.

15. The local NHS must intelligently commission to ensure that reducing smoking prevalence, particularly in more deprived groups is embedded within all healthcare services and fully maximise its opportunities as a commissioner of internal NHS and external services to influence both public and private sector employers and service providers to offer stop smoking support to employees.

The effectiveness of the Department of Health in co-ordinating policy with other government departments, in order to meet its Public Service Agreement targets for reducing inequalities;

16. The Department of Health has proved through the successful implementation of smokefree legislation that it can work across departments on tobacco control issues. It will be important to ensure that a cross-departmental approach is maintained, eg Easy access to cheap illicit tobacco keeps many poorer smokers addicted and sabotages their quit attempts and this is clearly not an issue that the Department of Health leads on. The PSA Target to reduce smoking prevalence in routine and manual groups to 26 per cent or less by 2010 will not be met in the absence of a comprehensive strategy to reduce the availability of cheap illicit counterfeit and smuggled tobacco.

Whether the Government is likely to meet its Public Service Agreement targets in respect of health inequalities.

17. Nationally, the Government is currently unlikely to meet its target of reducing prevalence amongst manual groups from 32 per cent in 1998 to 26 per cent or less by 2010 without a huge focus and investment in supporting this group to quit. It is estimated that if the routine and manual group target were to be met the PSA target for general smoking prevalence in the population would also be met. The North West population comprises significant numbers of smokers who fall within this category and further investigation of the modest success we have achieved in reducing prevalence in this group to date is warranted given that no other English region has replicated this.

18. Smoking Kills targets to reduce smoking in pregnancy and PSA targets to increase life expectancy at birth are closely linked and many parts of the North West are not likely to meet these targets. More work is needed to embed systematic approaches to supporting pregnant women to quit as part of maternity services. Smoking partners of pregnant women must also be engaged in this process due to the significant impact of second-hand smoke on the unborn child.

19. PSA Targets for reducing both Coronary Vascular Disease and Cancers are also unlikely to be met in the lower social groups without reducing smoking prevalence in those groups.

January 2008

Memorandum by the RCPCH (HI 25)

HEALTH INEQUALITIES

EXECUTIVE SUMMARY

Inequalities in childhood have an effect across the life course, and poor circumstances early in life adversely affect education, relationships, physical health and other determinants which have a major impact on the achievement of a child's potential. RCPCH recommends that a higher priority is given to children's rights within the health service and to training of staff on the use of the UN Convention on the Rights of the Child, as a key means of reducing inequalities.

Questions posed by the committee (we confine our responses to the public health aspects):

1. The effectiveness of public health services at reducing inequalities by targeting key causes such as smoking and obesity

There is some evidence that health promotion interventions in children may increase health inequalities since the uptake may be higher among more advantaged groups. For many specific problems such as obesity and child injuries, there are broad social determinants which must be tackled by cross government measures rather than just through the Department of Health. However the situation could be improved by:

- Linking health outcome data in children to social gradient. This can be applied to the work of individual clinicians and Dr Fawzia Rahman working in Derby has shown that community paediatricians are highly effective in reaching vulnerable families owing to their outreach approach. (*Rahman F., personal communication 2007*)
- Ensuring that new strategies, if not evidence-based, are well evaluated
- Giving a higher priority to child injury prevention within the health service and ensuring there is linkage with local community-based measures to prevent child injuries.
- Making Child and adolescent mental health services more accessible, linking them to primary care teams through the appointment of primary mental health nurses and relating them more closely with the work of schools. Such measures would have the effect of increasing access by socially disadvantaged families.
- Much can be done to reduce inequalities in mental health by focusing services on the early years, specifically parenting support. We recommend universal parenting programmes based in primary care using evidence-based methods. There should also be effective collaboration with education in the early years to ensure that children under 3 who are identified within the health service as having multiple problems related to deprivation receive educational support, and that this is extended to children with behavioural as well as physical difficulties.

2. Whether specific interventions to tackle inequalities such as Sure start have proved effective

Sure Start has been extensively evaluated and we do not wish to add to this, except to note that life course and intergenerational influences have long latent periods so the full benefits of such programmes may not be apparent for a considerable period and sometimes not for one or two generations. We would recommend that health visitor and school nurse adviser coverage be related to deprivation index and that the effect of this measure be evaluated.

Further, health visitor and school nurse services are under threat and posts are being lost. It is essential for central government to ensure that new targeted initiatives directed at specific localities do not adversely affect staffing in surrounding areas, which may have only slightly lower deprivation indices, and make it harder for them to recruit staff. It is likely that children's centres will need to be heavily supported by health visitors. In order, particularly to reach those who are least likely to use services provided. It is unlikely that the outreach workers from such centres will have sufficient training and expertise without such support.

3. The success of NHS organisations at coordinating activities with other organisations

We are concerned at the low level of the expertise on child public health available in many primary care trusts and strategic health authorities. Despite the significance of child health inequalities for the reasons given above, there are few posts with a special or sole interest in child health and the appointment of more public health specialists in child health would be of much benefit.

Our impression is that PCTs do not prioritise collaboration with the LA and that a minority of health staff are engaged in this work. This is reflected quite clearly in the different degrees, to which health influences the agenda of the Children and Young Person's Strategic Partnerships. This is likely to be addressed only by ensuring appropriate expertise is present in leadership positions within PCTs.

The National Service Framework for Children, Young People and Maternity Services, which aims to ensure a reduction in inequalities, was not additionally funded and has no specific targets and in many districts is not being fully implemented. Efforts are being made now to redress this balance but it is likely that funding will be required including budgets which promote inter-agency working in child health.

4. The effectiveness of the DH in coordinating policy with other government departments

The DH's effectiveness in leading on children's health equality issues has been complicated by a number of issues, most particularly by the pre-eminence of adult priorities which may conflict with children's needs. The formation of the DCSF, as a department with a sole focus on children, may help redress some of the conflicts that the DH has to face. We also believe that a strong department such as the Treasury may take the lead on co-ordination for some relevant issues; this has precedents in the Treasury leadership of the Sure Start programme.

5. Increasing access to health care

RCPCH would like to add a comment on means of improving access to health care by lower socioeconomic groups, which is not mentioned above. Access to both primary and secondary care could be improved and we highlight key factors here:

- Asylum seekers are a high risk group with low income and there is a possibility that they will be charged for health care. We would oppose this retrograde step.
- Health Professionals working with children should have mandatory training in cultural competence and in the application and use of the UN Convention on the Rights of the Child within the health services.

January 2008

Memorandum by Cancer Research UK (HI 26)

THE CONTRIBUTION OF THE NHS TO REDUCING HEALTH INEQUALITIES

1. BACKGROUND INFORMATION

Cancer Research UK is the world's largest independent organisation dedicated to cancer research; in 2006–2007 our research spend was £315 million. We welcome the opportunity to respond to this inquiry.

2. Cancer is a major cause of illness with more than 280,000 people diagnosed each year in the UK. It is also the biggest cause of death in the UK, accounting for 1 in 4 deaths.¹⁹⁶ There are significant inequalities in cancer incidence, mortality and survival. The risk of being diagnosed with certain cancers is greater among the most deprived families and communities. At the same time, although survival rates for most types of cancer have been improving since the 1970s, the survival gap between the most and least affluent has been increasing as those at the top are most able to take advantage of these improvements.^{197, 198}

3. CONTRIBUTION OF THE NHS TO REDUCING HEALTH INEQUALITIES

Cancer Research UK believes that the NHS has a central role to play in a government wide, coordinated approach to reducing health inequalities. Our submission to this inquiry will focus upon three areas:

- The need to address tobacco use, through early prevention and targeted public health messages and services, before it creates increased rates of disease (often referred to as upstream policy or service provision)
- The provision of information and support to patients and health service providers
- Increasing access and uptake of services among harder to reach groups.

4. THE NEED TO ADDRESS TOBACCO USE, THROUGH EARLY PREVENTION AND TARGETED PUBLIC HEALTH MESSAGES AND SERVICES, BEFORE IT CREATES INCREASED RATES OF DISEASE

Smoking is a major cause of health inequalities across the UK. Ninety per cent of lung cancer cases are caused by smoking, and lung cancer incidence is around 2.5 times higher among men and over three times higher among women, in the most deprived groups compared to the least deprived. Thirty-one per cent of those in routine and manual groups smoke (compared with 26% in the general population) and with overall prevalence declining by only 0.4% per annum, further sustained work is needed to attain the Government's target of 26% prevalence in routine and manual groups or less by 2010 and exceed this target in future years. It is also important to break the intergenerational cycle of tobacco dependence through smoking prevention programmes. Children who grow up with parents who smoke are three times more likely to smoke themselves.¹⁹⁹ We also know that smoking is a key contributory factor to child poverty.²⁰⁰

5. Although the desire and motivation to give up smoking does not have a socio-economic gradient, those in deprived areas have lower long term success rates,²⁰¹ possibly due to greater external life pressures. The NHS should continue to provide targeted information and support services within deprived communities. However, further research is needed to make these targeted approaches as effective as possible.

¹⁹⁶ Cancer Research UK (2007) *CancerStats Factsheet Men's Cancers*

http://publications.cancerresearchuk.org/WebRoot/crukstoredb/CRUK_PDFs/CSFSMENS.pdf

¹⁹⁷ Office for National Statistics (2005) *Cancer Atlas of the UK and Ireland*.

¹⁹⁸ Coleman M *et al* (2004) Trends and socioeconomic inequalities in cancer survival in England and Wales up to 2001, *British Journal of Cancer*, 90.

¹⁹⁹ Farkas *et al* (2000) *Association between household and workplace smoking restrictions and adolescent smoking2*, *Journal of American Medical Association* 284:717–22.

²⁰⁰ BMA Board of Science (2007) *Breaking the cycle of children's exposure to tobacco smoke*

[http://www.bma.org.uk/ap.nsf/AttachmentsByTitle/PDFbreakingthecycle/\\$FILE/Breakingcycle.pdf](http://www.bma.org.uk/ap.nsf/AttachmentsByTitle/PDFbreakingthecycle/$FILE/Breakingcycle.pdf)

²⁰¹ Bauld *et al* (2003) *Impact of UK National Health Service smoking cessation services: variations in outcomes in England*, *Tobacco Control* 2003; 12: 296–301.

6. Treating smoking related diseases costs the NHS an estimated £1.5 billion per annum.²⁰² At the same time, a one per cent decline in the smoking rate could save around 60,000 lives in only ten years and reduce the cost to the NHS by hundreds of millions of pounds (NICE also found that smoking cessation services were cost effective).²⁰³ Examples of where this money would be saved include reductions in the average amount of time spent in hospital following an operation, fewer premature and low weight babies, and fewer heart attacks and strokes. A comprehensive and targeted approach is needed that builds on recent policy success and works to reduce smoking incidence and encourage quit attempts. Total funding for a comprehensive tobacco control strategy to reduce smoking prevalence, not including the cost of smuggling initiatives, would be under £250 million a year. This should include spending on social marketing at double the current levels (£50 million a year instead of the current spend of around £25 million a year). It would also require maintenance of effective funding of the NHS Stop Smoking Services, currently £56 million per annum, and their extension to ensure effective smoking cessation provision in hospitals.

7. Smoking rates are higher among some BME communities, for example tobacco consumption could be as high as 60 per cent among the Bangladeshi community.²⁰⁴ Cancer Research UK has been working with this community, in the Tower Hamlets area of London, to raise awareness of the risks of tobacco consumption; evaluation of the pilot found an increase in awareness of the campaign and its key messages.²⁰⁵ The NHS could work collaboratively with the charitable and private sectors to deliver health messages that meet the needs of the UK's diverse communities.

8. THE PROVISION OF INFORMATION AND SUPPORT TO PATIENTS AND HEALTH SERVICE PROVIDERS

Early diagnosis of cancer is positively correlated to survival rates and it is therefore essential that the public have high rates of cancer symptom awareness. Current research suggests that this is not the case, for example:

- Grunfeld *et al*²⁰⁶ (2002) found low levels of breast cancer symptom recognition among older women, despite the risk of developing the disease being highest amongst this group²⁰⁷
- Cancer Research UK²⁰⁸ (2007) found that those from less privileged backgrounds were around 20 per cent less likely to recognise cancer symptoms compared to those from a more affluent background.
- Breast Cancer Care²⁰⁹ (2005) found that 38% cent of BME women questioned thought that a lump was the only symptom of breast cancer compared to just over twenty per cent of women in the general population.

9. Appropriate information and support is essential if individuals are to increase their knowledge of, and make, healthy lifestyle choices. Such information also enables individuals to access services appropriate to their needs and act upon treatment advice. For harder to reach communities it is often necessary to tailor information and support to meet their needs and the NHS is well placed to provide such information, in collaboration with other stakeholders if required.

10. Health inequalities could remain unchanged if translated information is inappropriate to the needs of BME communities, and other groups that require additional information and support. The NHS could undertake research to better understand the effectiveness of translating health information into languages other than English and other formats. As well as establishing good practice in providing information and support to harder to reach communities and groups.

11. At the same time, health care providers need to be enabled to communicate effectively with individuals from harder to reach groups. This could be achieved by the NHS carrying out research to better understand the effectiveness of training programmes for health care providers, in terms of increasing their ability to successfully communicate health information. Such training could then be rolled out, where appropriate, to ensure that health care providers feel confident when communicating with harder to reach communities.

²⁰² Parrott S, Godfrey C, Raw M, West R, McNeill A. Guidance for commissioners on the cost effectiveness of smoking cessation interventions. Thorax 1998; 53 Suppl 5 Pt 2:S1–38.

²⁰³ NICE Public Health Programme Draft Guidance http://www.nice.org.uk/nicemedia/pdf/Smoking_Cessation_Programme-Draft_Guidance-11_5_07.pdf

²⁰⁴ Department of Health (2004) Health Survey for England: Health of ethnic minorities.

²⁰⁵ Croucher, R. and Gamboa, A. (2006) *CR-UK Open up to Mouth Cancer campaign in Tower Hamlets: Final Report*, Queen Mary University of London/ Cancer Research UK.

²⁰⁶ Grunfeld *et al* (2002) *Women's knowledge and beliefs regarding breast cancer British Journal of Cancer*, (2002) 86, 1373–1378.

²⁰⁷ A Cancer Research UK funded study by Oxford University also found that less than one per cent of women knew that women over 80 are of greatest risk of developing breast cancer.

<http://info.cancerresearchuk.org/news/archive/pressreleases/2007/may/318252>

²⁰⁸ Cancer Research UK: Reduce the Risk

<http://info.cancerresearchuk.org/news/archive/pressreleases/2007/june/332451>

²⁰⁹ Breast Cancer Care (2005) *Same Difference: Policy Briefing*

http://www.breastcancercare.org.uk/docs/same_difference_final_0.pdf

12. INCREASING ACCESS AND UPTAKE OF SERVICES AMONG HARDER TO REACH GROUPS

As mentioned previously, early diagnosis of cancer is likely to increase an individual's chance of surviving the disease, for example women who are diagnosed at the earliest stage of breast cancer are 26 times more likely to survive than those diagnosed at the latest stage.²¹⁰ Screening is one such way that earlier diagnosis can be achieved. There are currently inequalities in uptake within all three cancer screening programmes based around socio-economic²¹¹ and or BME status²¹², disability²¹³, sexual orientation²¹⁴, and age²¹⁵. All English screening centres undertake their own awareness raising programmes and the NHS could disseminate information about best practice relating to the needs of communities and groups with traditionally low screening uptake. Research could also be undertaken to better understand, and reduce, the barriers that exist to uptake of screening services among the groups mentioned above.

13. The NHS could specifically address inequalities in uptake between regions; London consistently has uptake rates ten per cent lower than the UK average. The targeting of messages, which illustrate the importance of attending screening, to harder to reach groups could also be developed by the NHS.

14. Cancer Research UK is currently running a campaign, called Screening Matters, to promote screening for cancer.²¹⁶ Through this campaign we are calling on the Government to develop methods to increase the uptake of cervical, bowel and breast screening. Studies indicate that a range of policies, running alongside the screening programmes, including community-based and GP education programmes and improved participation of GP services can have an impact.^{217, 218, 219} Furthermore, sending second invites to patients with fixed appointments may be helpful.²²⁰

15. Cancer Research UK is aware of the difficulties of compiling accurate figures relating to the number of adults not registered with a GP. This group is often made up of the hardest to reach, for example transient populations, those who do not speak English, the homeless and new migrants to the UK. The NHS could reduce health inequalities between such groups and the rest of the population by increasing registration with GPs, through awareness raising and improved service provision, and by developing alternative access routes to health services for those not registered with a GP. Examples of this could include culturally appropriate mobile health units or providing services to rural communities. The NHS could also establish ways of encouraging GPs to practice in deprived/ rural areas, for example through incentives, to ensure that such communities have equal access to primary care.

16. The annual GP survey undertaken by DH²²¹ revealed wide variations in the numbers of GPs across England, with particularly acute problems in deprived areas. For example, Barking and Dagenham PCT in London had 43 GPs /100,000 population, compared with Northumberland PCT—88 GPs /100,000 population with an English average of 61/100,000 population.

17. Studies have shown that the standardised mortality ratio for all-cause mortalities at 15–64 years of age is lower in areas with a greater supply of general practitioners;²²² and that each additional general practitioner per 10,000 population is associated with about a 6% drop in mortality.²²³ Furthermore the supply of general practitioners is more closely associated with lower in-hospital standardised mortality than is the total number of physicians per 100 hospital beds.²²⁴

18. Practice based commissioning should enable groups of GPs to accurately assess the needs of their practice populations and commission services that meet those needs. For example, practices situated in areas with a large Afro-Caribbean male population might commission prostate awareness and prevention services, in order to tackle the higher rates of the disease among this group.

²¹⁰ Ugnat *et al* (2004) *Survival of women with breast cancer in Ottawa, Canada: variation with age, stage, histology, grade and treatment*, British Journal of Cancer 22; 90 (6) 1138–1143.

²¹¹ Henley *et al* (2005) *Does deprivation affect breast cancer management?* British Journal of Cancer; 92: 631–633.

²¹² Breast Cancer Care (2005) *Same difference: policy briefing*, London: Breast Cancer Care.

²¹³ Stein and Allen (1999) and Biswas *et al* (2005).

²¹⁴ Bailey *et al* (2000) *Lesbians and cervical screening*, British Journal of General Practice; 2000: 481–482

²¹⁵ National Statistics Online (2005)

http://www.ic.nhs.uk/webfiles/publications/brstscrnprogeng2005/BreastSCreeningProgramme280206_PDF.pdf

²¹⁶ www.cancercampaigns.org.uk

²¹⁷ Majeed *et al* (1997) *Impact of follow up letters on non-attenders for breast screening: a general practice study*, Journal of Medical Screening; 1997: 4: 19–20.

²¹⁸ Sharp *et al* (1996) *Breast screening: a randomised controlled trial in UK general practice of three interventions designed to increase uptake*, Community Health 1996; 50: 72–6.

²¹⁹ Thomas V.N. (2005) *Barriers to effective uptake of cancer screening among black and minority ethnic groups* International Journal of Palliative Nursing, Vol. 11, 11, p. 562–571.

²²⁰ Stead M.J.I.; Wallis M.G.I.; Wheaton M.E.I (1998) *Improving uptake in non-attenders of breast screening: selective use of second appointment*, Journal of Medical Screening, 5:69–72.

²²¹ Department of Health (2007) *GP Patient Survey: Your doctor, your experience, your say*. London: DH.

²²² Gulliford, M.C. (2002) *Availability of primary care doctors and population health in England: Is there an association?*, Journal of Public Health Medicine Vol. 24, No. 4. p.252–254.

²²³ *Ibid.*

²²⁴ Jarman B, Gault S, Alves B, Hider A, Dolan S, Cook A, Hurwitz B & Iezzoni L.I. *Explaining differences in English Hospital Death rates using routine collected data*, BMJ 318: 1515–711999.

19. CONCLUSION

Although a number of the causes of health inequalities are outside the remit of the NHS there are also a number of programmes that it could be undertaking, in collaboration with other stakeholders, to dramatically reduce health inequalities within the UK population. These relate to:

- Providing patients with the information they need in order to raise awareness of healthy lifestyles (particularly smoking prevention and cessation) and encourage the uptake of such behaviours.
- Enabling health service providers to communicate effectively with patients from harder to reach groups in order to disseminate health information.
- Ensuring that services are provided in a way that is accessible by harder to reach groups and reduces inequalities in uptake.
- Reducing the number of individuals who are not registered with a GP and establishing alternative access routes to health services.
- Reducing tobacco consumption among harder to reach groups through ensuring policies will reduce inequalities and providing targeted smoking cessation services.
- Working in collaboration with a range of stakeholders to ensure that services are provided in a way that meet the needs of the hardest to reach communities and groups.

20. Cancer Research UK funds and collaborates with a number of leading researchers in the field of health inequalities. We would be delighted to have the opportunity to contribute to any future sessions being undertaken by the Health Committee in relation to gathering information about health inequalities, and effective methods of reducing them.

21. OUR GOALS

In order to support our vision “together we will beat cancer” Cancer Research UK created ten ambitious new goals that, together with our partners, we are aiming to achieve by 2020. The goals are wide ranging and seek to clarify our priorities and enable us to demonstrate our progress and impact in a range of areas including reducing cancer incidence, ensuring patients have access to the information they need and reducing cancer inequalities.²²⁵

22. We are currently embarking on a new area of work, including the publication of two health inequalities reports in early 2008. Should you require copies of these reports, or further information about any of our health inequalities related projects please do not hesitate to contact us.

January 2008

Memorandum by the Reaching Out Project, Medact (HI 27)

HEALTH INEQUALITIES

1. ABOUT THE REACHING OUT PROJECT, MEDACT

The Reaching Out Project, Medact aims to improve access to maternity care for marginalised women from Black and minority ethnic communities.

Medact is a membership organisation of health professionals. Medact speaks out for countless people across the globe whose health, wellbeing and access to proper health care are severely compromised by the effects of war, poverty and environmental damage.

2. BACKGROUND

This submission focuses on maternal health of marginalised women from Black and minority ethnic communities.

Maternal health outcomes for this group are significantly worse than for the White population. The recent report of the Confidential Enquiry into Maternal and Child Health found that Black African women have maternal mortality rates 5.6 times higher than White women; Black Caribbean 3.7 times higher; Middle Eastern 2.9 times higher; “Other” 2.5 times higher; Bangladeshi 2.1 times higher; Indian 1.9 times higher; and Chinese and other Asian 1.3 times higher (Lewis 2007a:30).

²²⁵ A full list of our goals is available at: <http://www.cancerresearchuk.org/aboutus/whoweare/ourgoals/>

Maternal mortality rates for refugees and asylum seekers are extremely high. In the period 2003–2005, 36 of the 295 maternal deaths in the UK were of refugees and asylum seekers (Lewis 2007a). The total number of refugee and asylum seekers births was not known, so a mortality rate could not be calculated. As a rough indication, 12% of maternal deaths in 2003–2005 were to refugee and asylum seeking women while the UN High Commission for Refugees estimates that refugees make up about 0.3% of the UK population.

Infant mortality data does not yet permit a comprehensive analysis by ethnic background. The limited data which is available indicates significantly worse health outcomes to children born to Black and minority ethnic mothers. The infant mortality rate for children of mothers born in Pakistan was 10.2 per thousand live births in 2002–2004 and 8.3 per thousand live births where the mother was born in the Caribbean (Department of Health 2007). These are, respectively, 108% and 63% higher than the national average.

Many births to marginalised women from Black and minority ethnic backgrounds will fall within the “NS-SEC Other” category. This group has an infant mortality rate of 9.3 per thousand live births which is 90% higher than the population as a whole (Department of Health 2007).

3. TERM OF REFERENCE

1: *The extent to which the NHS can contribute to reducing health inequalities, given that many of the causes of inequalities relate to other policy areas eg. taxation, employment, housing, education and local government*

3.1 Eligibility for free NHS maternity care

Free NHS maternity care is available to women who are considered to be “ordinarily resident” in the UK or who fit within certain defined categories. Women who are not entitled to free NHS care will be charged for their care but care cannot be refused on grounds that a woman is unable to pay. Department of Health guidance states that this is because of the severe health risks associated with conditions such as eclampsia and pre-eclampsia (National Health Service 2004)

One objective of the current regulations is to address “health tourism”. A “health tourist” is a person who comes to the UK with the express purpose of making use of free NHS services. While there have been various statistics produced on the costs of overseas visitors to the NHS, these have not been disaggregated. In addition to any “health tourists” who obtain free NHS care, these figures include people who have travelled to the UK in order to receive care as private patients and have paid for this care, and those who are living in the UK but are liable to pay for care because of their immigration status.

Amongst the women who are not entitled to free NHS maternity care are many vulnerable migrants, including asylum seekers whose appeals have been exhausted (“refused asylum seekers”), trafficked women and undocumented migrants. These women have not come to the UK in order to obtain health care and may have lived in the UK for some years before seeking treatment. Project London provides health services to undocumented migrants. In its first year of operation the average service user had been in the country for three years ((Project London 2007), indicating that service users had not come to the UK in order to seek health care.

The financial circumstances of these women are often extremely difficult. They are not permitted to work or to obtain state benefits. A small number of women receive subsistence support from NASS. Many destitute women rely on support from church, community groups and friends. They do not have the funds to pay the charges for maternity care, which range from £1500 to in excess of £3000 for a normal vaginal delivery. Neither are these women in a position to negotiate repayment plans as their future may be very uncertain.

The policy of charging for maternity care has the effect of deterring women from obtaining care. Many women are intimidated by the prospect of incurring a debt of several thousand pounds when they know it will be impossible to repay it. They therefore choose not to receive care they cannot afford, and disappear from maternity services (Joint Committee on Human Rights 2007, Kelley & Stevenson 2006). Some women are able to raise part of the sum but feel that they have no option but to discontinue the care when the money runs out. Some women are fearful that their irregular immigration status will be reported to the Home Office.

Lack of compliance with the policy has also resulted in women being denied or deterred from obtaining care. The Joint Committee on Human Rights inquiry into the treatment of asylum seekers 2006–7 specifically considered the misapplication of the rules by hospitals and the deterrent effect of the rules. The Committee concluded:

It is clear to us that there is considerable confusion. Pregnant women are denied, or fail to access, essential care as a result. The evidence shows that additional [Department of Health] guidance has not removed the confusion.

The Reaching Out Project has found numerous instances of the policy not being applied.

- Women have been refused care when they have arrived at the hospital in labour.
- Women have been refused care unless they can pay. In some cases the refusal has been communicated aggressively.

- Voluntary organisations advocating for individual women have found it extremely difficult to resolve disputes about entitlement to care. Advocates state that they have quoted the regulations and guidance without effect and the response from the Overseas Visitor Managers has often been extremely unhelpful and, in some cases, very rude.
- The process of negotiating access to care can take weeks or months, creating significant delays in accessing antenatal care.
- Women have experienced aggressive treatment from the Overseas Visitor Manager. Some have experienced harassment.
- Women have been contacted by debt collectors prior to the birth.
- Women who are entitled to free care have been wrongly denied free care because trust staff did not understand Home Office information.
- Overseas Visitor Managers have met with women who speak little or no English to discuss their entitlement without use of an interpreter, resulting in confusion.

As a result of this policy, many vulnerable women commence antenatal care late, receive intermittent care, or receive no antenatal care and attend only for the birth. There is also evidence of women giving birth alone and unattended (Kelley & Stevenson 2006). Suboptimal antenatal care is a major risk factor for maternal deaths and was present in 19% of maternal deaths investigated in the Confidential Enquiry into Maternal and Child Health report, *Saving Mothers' Lives* (Lewis 2007a). Antenatal care provides opportunities to identify and treat conditions including pre-eclampsia, eclampsia, gestational diabetes, and cardiac disease. The risk of a child being born with HIV is reduced from 30% to 1–2% if a HIV positive mother receives appropriate treatment.

The CEMACH report recommended improvements in service accessibility to promote early commencement of antenatal care (Lewis 2007a). The importance of this issue is reflected in the selection of indicators for the 2007 Public Service Agreements. Delivery Agreement 19, Indicator 4 is “the percentage of women who have seen a midwife or a maternity professional for health and social care assessment of needs, risks and choices by 12 completed weeks of pregnancy”. It is not possible to reconcile the current focus on promoting improved access to antenatal care with the policy of charging for maternity care.

At present, there is a strong financial disincentive for trusts to provide care to women who are not entitled to free NHS care. The trust is obliged to provide care to women who cannot pay for care, but there is no source of funds to cover this obligation. The introduction of Payment By Results means that the costs cannot be absorbed into block contracts. As a result, there is a financial penalty for trusts which provide maternity care to this group of vulnerable women.

3.2 *Proposals to deny eligibility to free NHS primary care to vulnerable migrants*

At the time of writing, a joint Department of Health and Home Office review was considering proposals to extend the current charging regime to primary medical services. This would have the effect of denying eligibility to free NHS GP services to vulnerable migrants, including refused asylum seekers, trafficked women and undocumented migrants.

The review was announced in a Home Office document, *Enforcing the Rules* (Home Office 2006) which described one of its aims as:
to ensure that living illegally becomes ever more uncomfortable and constrained until they leave or are removed.

This sits in contrast with the rationale for the 2004 regulations on charging for secondary care, which was to combat perceived abuses of the NHS by “health tourists”.

While government policy supports direct access to midwives, 83% of women first seek pregnancy care from their GP (Redshaw et al 2006). This rises to 86% for women having their first child. Charging for GP services may result in vulnerable migrants delaying the commencement of maternity care or not seeking it at all. Given evidence that vulnerable women are already being deterred from obtaining maternity care by requests for payment by maternity services, charging for GP appointments is likely to increase the proportion of women who do not obtain satisfactory antenatal care. Another deterrent factor is the increase in data sharing which is anticipated to accompany this policy, as this will add to women's fears that attending for care will bring them to the attention of immigration authorities.

The CEMACH report emphasised the importance of identifying any underlying health problems early in pregnancy, and recommended that women who are new to the UK undergo a full medical examination by a suitably trained doctor, such as the woman's GP (Lewis 2007a). It is unclear whether this would be considered part of maternity care and therefore “immediate and necessary” care. If this is not the case, then vulnerable migrants may be unable to obtain this examination unless they can pay. This places an already vulnerable group of women at further risk.

Charging for GP services also reduces the very limited support available to vulnerable migrants who are experiencing domestic violence. Women who are vulnerable migrants have particular difficulties in leaving an abusive partner. Women who are failed asylum seekers or undocumented migrants are not entitled to access emergency accommodation or receive welfare benefits. They may be left with the choice between remaining in an abusive relationship or destitution.

GPs provide an important source of health care to women experiencing domestic abuse and may assist in linking her to sources of support. Vulnerable migrants who are experiencing domestic abuse may not be able to obtain money from their partner or family to pay for GP appointments and so may lose this source of support.

For many women who are legally resident in the UK, their right to remain in the UK is dependent upon their husband. If they leave the relationship, they face deportation. For some women, deportation back to their countries of origin may mean violence and persecution for being divorced or separated. Many new migrants have, as a condition of their visa, “no recourse to public funds”. Women with “no recourse to public funds” are not entitled to access emergency accommodation, including women’s refuges and are not entitled to receive welfare benefits. Leaving the relationship may leave them destitute.

Women with “no recourse to public funds” who are escaping an abusive relationship may gain the right to remain in the country if they can provide evidence of the abuse. A letter from a GP is one of the few forms of evidence which is acceptable to the Home Office. Currently, women with “no recourse to public funds” are entitled to free GP appointments. If these women were to be charged to attend a GP appointment, they may not be able to prove to the Home Office that the abuse occurred.

3.3 Interpreters

Language support is fundamental to the provision of high quality health services to vulnerable women with limited or no English. Despite this, there are ongoing problems with provision of interpreting services including inappropriate use of family members to interpret and failure to use interpreters.

The CEMACH report documented the risks to patient safety associated with unsatisfactory language support (Lewis 2007a). In 34 of the 295 maternal deaths investigated, the women spoke little or no English and very few had access to interpreting services. Five women who were murdered by their partners had the abusive partner as their interpreter. In one case, diagnosis of tuberculous meningitis was delayed as the husband was acting as the interpreter. An asylum seeking woman who died from a complex set of conditions had her young son translating for her. Disturbingly, a GP reported that interpreting was a particular problem in his practice as there was no agreed source of funding for interpreters.

3.4 Female Genital Mutilation or Cutting (FGM/C)

The number of women with Female Genital Mutilation or Cutting (FGM/C) living in England and Wales is in excess of 66 000 (Dorkenoo 2007). This figure is expected to increase, largely due to migration from countries where it remains common practice. Despite the availability of education resources for healthworkers, awareness of the issue and standards of maternity care for women with FGM/C is variable.

Examples of unsatisfactory care for women with FGM/C are documented in the CEMACH report (Lewis 2007a). For one woman, late identification of FGM/C led to an unnecessary caesarean section and may have directly contributed to her death.

3.6 Other policy areas contributing to health inequalities

3.6.1 Destitution for refused asylum seekers

The Government’s policies and practices in relation to support for asylum seekers and refused asylum seekers have been widely criticised as inhumane and in breach of human rights. The Joint Committee on Human Rights inquiry into the treatment of asylum seekers (2007) concluded:

We consider that by refusing permission for most asylum seekers to work and operating a system of support which results in widespread destitution, the treatment of asylum seekers in a number of cases reached the Article 3 ECHR [European Convention on Human Rights] threshold of inhuman and degrading treatment . . . Many witnesses have told us that they are convinced that destitution is a deliberate tool in the operation of immigration policy. We have been persuaded by the evidence that the Government has indeed been practicing a deliberate policy of destitution of this highly vulnerable group.

The health impact of these policies is severe. A national study involving 125 asylum seekers found that many had experienced deteriorating health and a permanent state of depression, distress and anxiety (Refugee Action 2006). A study undertaken in Leeds concluded that destitution policies can have an acute impact on the wellbeing of refused asylum seekers and can lead to self-harm and suicidal thoughts (Lewis 2007b).

Of particular concern is “section 9”, which enables the Home Office to cease providing support for an asylum seeker with a dependent child if the family is not considered to have taken reasonable steps to leave the UK. In these circumstances, the local authority may take the child into care. According to Refugee Action, four children were taken into care during a pilot of section 9 in 2005 and a substantial number of families “disappeared” from their accommodation (Joint Committee on Human Rights 2007). These outcomes are manifestly not conducive to the good health of parents or children.

3.6.2 No recourse to public funds and domestic violence

The policy of providing “no recourse to public funds” to many new migrants creates significant problems for women experiencing domestic violence. Women with “no recourse to public funds” are not entitled to access emergency accommodation, including women’s refuges and are not entitled to receive welfare benefits. They are forced to choose between remaining in an abusive relationship or destitution if they leave the relationship.

This has particular implications for maternal health. It is estimated that 600 women who have insecure immigration status are subject to domestic violence from their spouse each year (Southall Black Sisters & Women’s Resource Centre 2005). Women who are pregnant are at particular risk of domestic abuse. In approximately 30% of domestic violence cases, the abuse began during pregnancy (Department of Health 2005). Of the 295 maternal deaths examined in the CEMACH report, 19 of these deaths were of women murdered by abusive partners (Lewis 2007a). 70 of the 295 women who died had features of domestic abuse (Lewis 2007a).

4. TERM OF REFERENCE

6: *The effectiveness of the Department of Health in co-ordinating policy with other government departments, in order to meet its Public Service Agreement targets for reducing inequalities*

The relevant PSA target for the current period is the infant mortality target:

Starting with children under one year, by 2010 to reduce by at least 10% the gap in mortality between the routine and manual group and the population as a whole

The relevant PSA for the CSR07 period of 2008–2011 is:

PSA Delivery Agreement 19, Indicator 4: The percentage of women who have seen a midwife or a maternity professional for health and social care assessment of needs, risks and choices by 12 completed weeks of pregnancy

4.1 Department of Health and Home Office policy coordination

Proposals to deny eligibility to free NHS primary care to vulnerable migrants, discussed at 3.2 above, are part of a joint Home Office/Department of Health review. As discussed above, the proposals under consideration in this review are likely to reduce timely attendance for maternity care and, consequently, are likely to have a negative impact on infant mortality. While there appears to be a high level of coordination between the Department of Health and the Home Office, this is not conducive to meeting PSA targets.

January 2008

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Memorandum by the British Fluoridation Society (HI 28)

HEALTH INEQUALITIES

1. In May 2007 the 60th World Health Assembly adopted resolution WHA60.17, endorsing the report *Oral health: action plan for promotion and integrated disease prevention* http://www.who.int/gb/ebwha/pdf_files/WHA60/A60_R17-en.pdf.

2. The Resolution acknowledged “the intrinsic link between oral health, general health and quality of life”, and urged Member States, inter alia, to:

- . . . promote the availability of oral-health services that should be directed towards disease prevention and health promotion for poor and disadvantaged populations . . . , and
- . . . to consider the development and implementation of fluoridation programmes, giving priority to equitable strategies such as the automatic administration of fluoride, for example, in drinking-water, salt or milk, and to the provision of affordable fluoride toothpaste . . .

3. In the UK, while tooth decay levels have fallen overall in recent years, inequalities in dental health remain wide. Improvements in dental health (mainly due to the introduction of fluoride in toothpaste) have not been evenly distributed across all social groups, and severe tooth decay remains a problem among young children in disadvantaged communities.

4. As a result of higher levels of disease, young children living in poverty suffer more of the problems associated with tooth decay: toothache, dental abscesses, and tooth extractions <http://www.bfsweb.org/One%20in%20a%20million/2.%20dental%20benefits.pdf>. This adversely affects their general health and quality of life.

5. The reduction of dental health inequalities is therefore an important goal and, although the small number of studies and their low quality rating suggest caution in interpreting these results, the York review <http://www.york.ac.uk/inst/crd/fluores.htm> found that, in terms of the average number of decayed missing and filled teeth, “there appears to be some evidence that water fluoridation reduces the inequalities in dental health across social classes in 5 and 12 year olds”.

6. An important study included in the York review looked at the dental health of 5-year-olds living in fluoridated and non-fluoridated areas of varying degrees of social deprivation (Riley *et al*, 1999).²²⁶ It concluded that water fluoridation reduces tooth decay more in disadvantaged communities than in affluent communities, and that the introduction of water fluoridation in areas where levels of poverty and tooth decay are high—such as Manchester—“would substantially reduce inequalities in dental health”. Figure 1 (reproduced from Riley *et al*, 1999) shows the relationship between tooth decay and social deprivation in both fluoridated communities and non-fluoridated communities. It demonstrates that:

- Young children living in poverty have higher levels of tooth decay than children from more affluent families.
- Water fluoridation reduces the effects of deprivation on tooth decay.
- Where the level of deprivation is the same, children in non-fluoridated communities have more tooth decay than those in fluoridated communities.
- The difference is just over one tooth per child at “average” levels of deprivation (ie Townsend score of zero), but importantly the difference increases as levels of deprivation increase.
- So, for example, at Townsend deprivation score of 10, children in non-fluoridated communities have around two more decayed teeth per child than children in fluoridated communities.
- The link between poverty and tooth decay is well established in non-fluoridated areas, but weaker in fluoridated areas.

²²⁶ Riley JC, Lennon MA, Ellwood RP (1999): The effect of fluoridation and social inequalities on dental caries in 5-year-old children. *International Journal of Epidemiology* 28: 300–305.

7. The York review summarised a number of UK studies investigating the relationship between tooth decay, social deprivation and water fluoridation (including the study described above). Five of the studies focussing on the dental health of 5-year-olds used the same classification of social class, so York were able to combine the results. The combined results are shown in Figure 2. Essentially,

- Across all social classes, the number of teeth affected by decay is lower in the fluoridated than the non-fluoridated communities; and importantly,
- The teeth of 5-year-old children in the lowest social classes (IV and V) in the fluoridated communities are as healthy as those of children in the highest social classes (I and II) living in the non-fluoridated communities—demonstrating that water fluoridation can modify the usual link between poverty and severe tooth decay.

8. Clearly water fluoridation is critically important if efforts to reduce persistently high levels of tooth decay—and thus reduce health inequalities—are to succeed.

9. In November 2003 Parliament, with substantial majorities on free votes in both houses, supported the Government’s proposal to correct the legislation (in England & Wales) so that water companies were no longer able to veto NHS decisions about water fluoridation. (Water Act 2003 Section 58(2) <http://www.opsi.gov.uk/acts/acts2003/20030037.htm>)

10. However, four years after the new legislation no new schemes have been implemented, and only one PCT, Southampton, has requested its SHA to undertake cost and feasibility studies. The SHA and PCTs in Greater Manchester, where dental health is among the worst in the country, originally mapped out a timescale suggesting that in Spring 2007 the PCTs would have sufficient information—in terms of mapping water distribution and caries levels, and cost-effectiveness—to decide whether or not to ask the SHA to undertake a formal fluoridation consultation. However, there is no indication as yet that the NHS in the North West has any firm timetable for a fluoridation consultation.

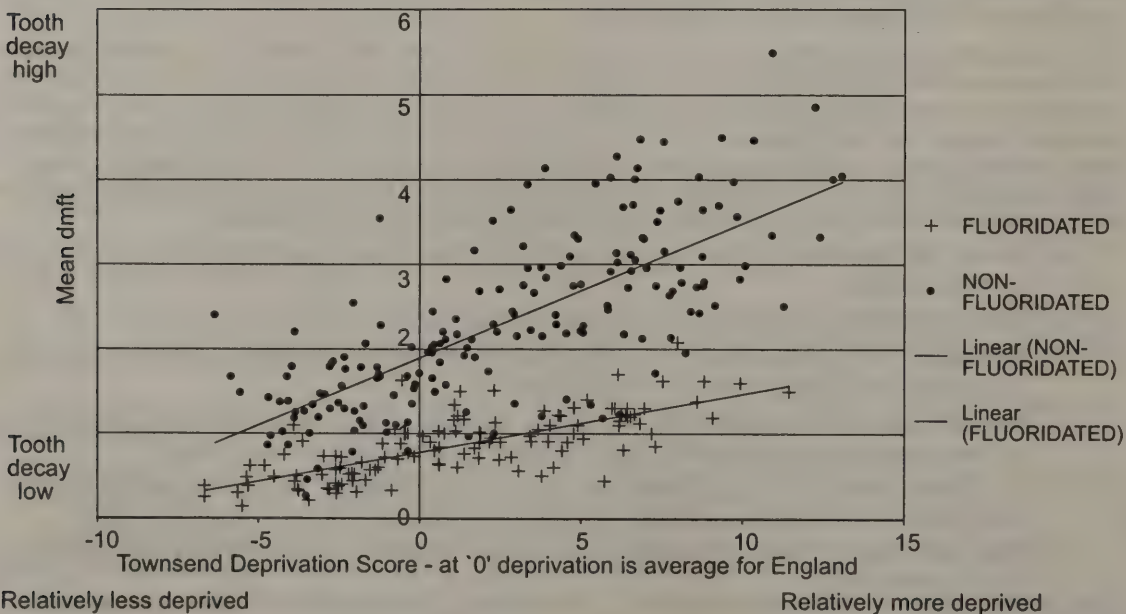
11. Elsewhere, there has been little information in the public domain to suggest that other PCTs might be actively considering fluoridation as part of their oral health policies. These delays are unacceptable.

RECOMMENDATION

12. We strongly urge the Health Select Committee to recommend that where the need has been established—for example in the North West of England and Yorkshire—health authorities will consult communities with a view to implementing new fluoridation schemes without delay.

7 January 2008

Figure 1 Relationship between tooth decay and social deprivation in fluoridated and non-fluoridated communities

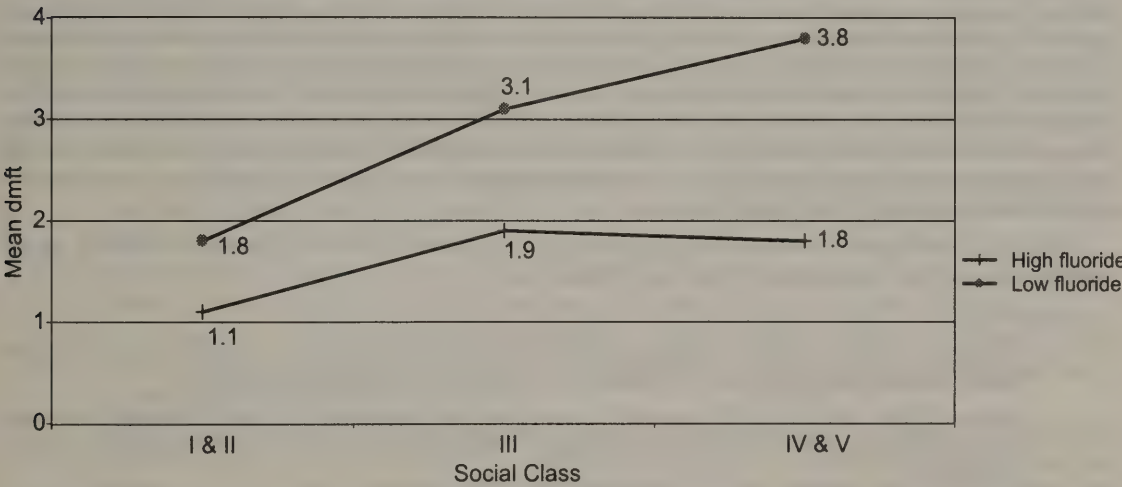


Graph reproduced from Riley *et al*, 1999 by permission of Oxford University Press.

Figure 1

- 1. The vertical axis represents the average number of decayed, missing or filled teeth (mean dmft) per 5-year-old child.
- 2. The horizontal axis represents the level of social deprivation in the community as measured by the Townsend deprivation score. (The average Townsend score for England is a score of 0. A very socially deprived community would have a score of + 10 or more. Whereas, a relatively affluent community would have a score of less than 0.).
- 3. Crosses mark the positions of each fluoridated community.
- 4. Dots mark the position of each non-fluoridated community.
- 5. Where the level of deprivation is the same, children in non-fluoridated communities have more tooth decay than those in fluoridated communities.
- 6. The difference is just over one tooth per child at “average” levels of deprivation (i.e. Townsend deprivation score of zero), but the difference increases as levels of deprivation increase.
- 7. At Townsend deprivation score of + 10, children in non-fluoridated communities have around two more decayed teeth per child than children in fluoridated communities.

Figure 2 Tooth decay in 5-year-old children by social class and water fluoridation - average number of decayed, missing and filled teeth per child (dmft)



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Memorandum by the Socialist Health Association (HI 29)

TACKLING INEQUALITIES THROUGH THE NHS

The Socialist Health Association was founded in 1930 to campaign for a National Health Service and is affiliated to the Labour Party. We are a membership organisation with members who work in and use the NHS. We include doctors and dentists and other clinicians, managers, board members and patients.

Our members are involved in a wide variety of consultation and involvement processes in health and social care. We have been particularly concerned about health inequalities for many years and many of our members are involved in work to reduce inequalities and in study of relevant areas. This submission is made on behalf of the Association. We would be very happy to give oral evidence to the committee.

The increase in the relative disadvantage of the poor has been continuing for a long time. Richard Titmuss, writing during the Second World War, concluded that, “the inescapable lesson of this study is that the infants of the poor are relatively worse off today than they were before the 1914 war.” (Titmuss, 1943). The Black Report concluded, “Perhaps the most important general finding [...] is the lack of improvement, and indeed in some respects deterioration, of the health experience not merely of occupational class V but also class IV in health, relative to occupational class I... during the 1960’s and early 1970s.” (DHSS, 1980). Sir Donald Acheson found, “that although the last 20 years have brought a marked increase in prosperity and substantial reductions in mortality to the people of this country as a whole, the gap in health between those at the top and bottom of the social scale has widened” (Acheson, 1998). This trend has persisted regardless of efforts, or lack of them, by governments of different persuasions, including the present one, for half a century or more (Scientific Reference Group on Health Inequalities, 2005).

Recent OECD figures show that Inequalities in wealth, which mirror inequalities in health, are greater in the UK than in most other developed countries and show no signs of reducing. In the period, 2003–06, the UK wealth 20:20 ratio was 7.2 with only Portugal and the US having higher ratios among the richest countries. The lowest ratio among these countries was 3.4, found in Japan. It seems very clear from the work of Sir Michael Marmot and Prof Richard Wilkinson that the increasing inequalities of wealth in our society—which grow wider during periods of economic growth—are the main drivers of inequality in health and that measures taken by the NHS will never be more than palliative.

Brian Abel-Smith argued: “if socialists believed forty years ago that all that was needed to equalise health status between social classes was to remove the money barriers to access to health care, they were seriously mistaken” (Abel-Smith, 1984). The scope for the NHS to contribute significantly to the reduction in health inequalities is very limited as demonstrated in the Acheson Report but this is no excuse for not using this scope to the maximum.

One of the underlying causes of the inverse care law must be that healthcare has been almost entirely demand led. Doctors wait for patients to come to them. It is not surprising that the most demanding patients demand and get a better service. Without affirmative action to identify the healthcare-deprived in order to provide appropriate high quality healthcare the NHS will continue to increase health inequalities because the health-advantaged currently get more out of it than the health-disadvantaged. Introducing more screening for those not currently exhibiting symptoms is likely to further exacerbate inequalities unless active steps are taken to counter this.

Affirmative action needs to take place at three levels—the Area level, the individual General Practice level and the focused Group level. Some Areas can readily be identified as comprising high numbers of healthcare-deprived people and here an Area-wide approach with increased provision of easily accessible relevant healthcare services such as health visitors, outreach outpatient and diagnostic services and branch surgeries is required. Recent advances in the use of information technology make some of these approaches much more practical. There are now a number of tools that analyse population patterns at postcode area levels. These approaches began in the commercial fields, it’s how supermarkets decide where their customers are and where to mount marketing activities but the same methods can be used to identify particular deprived groups who have specific health care needs.

One example is Experian’s Mosaic classification; by linking this sort of social data with health data a targeted approach at the community level is possible.

For example:

- Group F 37—[Low income younger families with children in small, hard to let blocks of public sector purpose built flats] are 3.8 times more likely to have teenage pregnancies
- Group I 50—[Old people in specially constructed accommodation mostly managed by local authorities, many with a resident warden] are 6.3 times more likely to have a preventable winter admission
- Group D 25—[Young, unattached people in small flats and older housing close to small town centres] are 3.3 times more likely to have an emergency mental health admission.

(Source Dr Foster Intelligence. See also the work of Dr Sohail Bhatti, recently DPH for Huddersfield).

This is outreach at the area level.

At individual GP level it should be possible to identify healthcare-deprived patients from the Practice List and then make contact with them to ensure that they take full advantage of all the relevant services they need. This should be supported and motivated by the creation of a QOF specifically related to the inequalities issue for which the EPIC-Norfolk Prospective Population Study provides an evidence base. Four simply defined behaviours—smoking, physical activity, alcohol drinking, and fruit and vegetable intake are shown to have an enormous influence on life expectancy, and it must be possible for these to be recorded and improved at practice level. This is outreach at the individual patient/family level.

There are also health-deprived people who are not on Practice Lists for various reasons, for example the homeless. For these people a focused group outreach approach is required with staff actively seeking out such people and taking whatever steps are necessary to ensure they get the healthcare they require.

Bearing in mind the importance of the wider determinants in health another important role for the NHS is for someone at GP Practice / Health Centre / Polyclinic level to develop what we term the neighbourhood / community public health role in order to initiate and coordinate local action to ensure that the wider determinants environment is optimised for the local population including the health/healthcare deprived population.

There are in our view three key platforms for delivering community health and wellbeing focused particularly on the health deprived namely:

- general practice
- community schools/colleges working in a coordinated way
- community development

Our proposed model envisages Practice premises or where they exist, Health Centres/ Polyclinics, providing a range of services, in addition to the traditional primary healthcare services, such as Benefits Advice and social services; and acting as a signpost to relevant services such as housing advice and environmental health. At the same time, by working with local community development workers, health protective social networks could be formed.

The local secondary school acting as a community school or college would provide education and lifelong learning opportunities as well as sports facilities and opportunities for social activities of various sorts. Public health leadership would be provided from the platform of the local GP Practice or Health Centre/ Polyclinic either by a suitably trained General Practitioner, or more likely, by a health visitor or health promoter working within the primary care team and relating to the local community and its key institutions, often through community development. This approach to developing community public health harks back to the revolutionary model adopted in the Peckham Pioneer Health Centre in the 1930s.

In addition we propose that:

1. All new NHS policies, programmes and projects should be subject to both a healthcare accessibility inequalities assessment and a healthcare quality inequalities assessment.
2. Similarly, all NHS public health policies, programmes and projects should be subject to a broadly based health and wellbeing inequalities impact assessment.
3. As recommended by the Acheson Report, all government domestic policies, programmes and projects should be subjected to such an assessment as all have some impact on health and on health inequalities.
4. Responsibility for tackling inequalities at national level must be allocated to a senior civil servant and a senior politician of cabinet rank; similarly, responsibility at local level must be allocated to a senior official and a cabinet rank councillor within local government; and to equivalent officers and members in Primary Care Trusts and NHS Trusts. It is crucial that these named officers, politicians and members have cross-departmental/divisional responsibilities and powers
5. It must be a mandatory duty on the national government and on local authorities and NHS primary care and hospital Trusts to produce an annual account of their actions and the results of these actions to reduce inequalities.
6. The designation of the reduction in inequalities as a key performance indicator for the NHS and Public Health must be matched by a clear line of accountability at all levels for delivery.
7. The resource allocation formulae used to distribute funds to local authorities and Primary Care Trusts should, as specifically recommended in the Acheson Report, give more weight to measures of health and material deprivation.
8. Inequalities issues almost invariably require cross-cutting action involving primary care, secondary care and public health elements of the NHS as well as one or more arms of local government and in many cases voluntary and community organisations too. Coordination and energisation of such action, often by means of LAA's and JNAS's, through local collaborative partnership working is crucial to success.

Below are two specific contributions from SHA members which we fully support.

January 2008

Annex

HEALTH INEQUALITIES AND WHY WE FAIL TO CHANGE THEM

Prof Rod Griffiths

Inequalities in health outcomes have been with us a long time. The geographical pattern of lower life expectancies in some areas associated with poverty has been roughly similar across the country for the lifetime of everyone living in the UK. There have been some variations as the population has grown and the built area has expanded but the basic pattern has persisted. One major reason for this is the planning acts which have now been in place in one form or another for a lifetime. These acts work to keep the country looking like it always has, in other words it keeps poor people in poor places, maintains differentials in property prices and housing density, keeps industry in the same places, determines transport patterns and so on. The effect is to preserve geographical inequalities.

As an example, when I was first a DPH in the 1980s and 90s it used to be the case in Birmingham that the almost only way you could get to live in Nechells was to not pay the rent somewhere else, the housing department would then move you to Nechells. There were other sink estates but at the time that I first became DPH in Central Birmingham about 85% of the people in Nechells were on some sort of benefit. Those who did get a job moved out as fast as they could and were replaced by someone else who was down on their luck. Nothing that the health authority did was likely to alter the pattern of health inequality

because the benefit, planning and housing systems made sure that things stayed the way that they were. To large extent these policies followed social expectation and electoral pressures. Things stayed the way they were because the majority of the population expected them to be that way.

Some things did change. In the 60s the housing in Nechells was transformed, the old slums were demolished and replaced by tower blocks, but the pattern of income distribution stayed the same. Old factories were demolished and replaced by modern facilities. As a result, although unemployment was high, what work there was, was safer. Pro rata industrial accidents and sickness at work were lower in Nechells than in some parts of Birmingham where the buildings were not demolished.

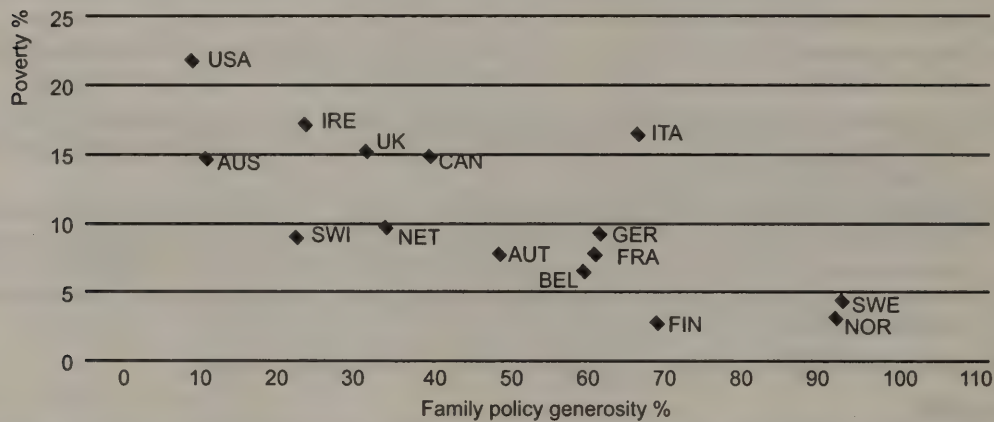
Across the UK similar patterns persist. If we measure health inequalities on a geographical basis then rapid change is very unlikely.

The second lesson from history is that although the pattern has remained fairly constant the actual causes of death have changed. A hundred years ago the poor died from infectious diseases made more likely by overcrowding and poor sanitation. Later respiratory disease caused by air pollution became more prevalent and now the poor die from smoking and obesity, which used to be afflictions of the rich.

Obviously the medical model is effective in seeking cures for the individual diseases but it does not work to tackle inequalities. As one disease is cured it is replaced by another and the social processes of our society work to ensure that the poor will die sooner than the rich. HIV is the latest disease to change its pattern in this way. We first saw it as a disease of well off and hedonistic homosexuals but across the world it has rapidly become a scourge of the poor and black, while death rates in the rich, whatever their sexual orientation, have fallen rapidly.

Across the world we see similar patterns but the relative steepness of the gradient between rich and poor varies considerably in different countries. It is a sad fact that the UK has some of the greatest health inequalities. The figure below, taken from the UN Commission on Social Determinants of Health gives some idea why this is. Most of Europe is more generous in its support to families than the UK or USA and as a result has better health inequalities and in most cases longer life expectancy.

Figure 9: Total family policy generosity and child poverty in 15 countries, 2000 or nearest



Notes: Net benefit generosity of transfers as a percentage of an average net production workers' wage. Poverty line 50% of median equivalised disposable income.

Source: Lundberg et al, 2007, based on Luxembourg Income study data.

Notes: Net benefit generosity of transfers as a percentage of an average net production workers' wage. Poverty line 50% of median equivalised disposable income.

Source: Lundberg *et al.*, 2007, based on Luxembourg Income study data.

The UN commission concludes that “The devastating health inequities we see globally are man-made. The causes are social—so must be the solutions. A global society in which millions of children and adults are unable to lead flourishing lives is not sustainable.”

Do Hospitals make a difference?

Treating diseases is obviously a good thing. Few studies have looked at what happens inside hospitals, many years ago I analysed the outcomes of treatment from heart attacks looking at the case fatality rate for different income and poverty groups. I selected heart attacks as being something where there were less likely to be social barriers to immediate admission. There was very little difference in outcome between rich and poor. Once a patient is admitted to hospital the NHS pays very little attention to issues like income, housing tenure, car ownership, education or any other markers of income and social status but there is a big difference between rich and poor when we look at outcomes at a population level. The damage is done outside hospital. Some of the problem may be in primary care, GP list sizes are often bigger in poorer areas

and the quality of care is often less good. There are of course heroic examples of GPs in poor areas who have done exceptional work over many years. Some, like Julian Tudor Hart have published their methods and results but their work has not been taken up universally and the lessons have not been translated into government policy or driven into practice by the NHS.

There are deep attitudes in British society that accept and reinforce social determinants of health. I once suggested that everyone from poorer areas should be given a three month start on the waiting list on the grounds that poorer access and education would have delayed their presentation with whatever condition that they had. I tried the suggestion on a number of audiences, both lay and professional and was always told that it wouldn't be fair, despite the fact that the current outcomes are manifestly not fair. As one GP said to me some years ago "If I've got two patients who need a CAGB and one runs Rover and the other is a down and out, I can't send the down and out in ahead of the chap from Rover, can I—I think about all those jobs that depend on him." As long as we tend to think like that health inequalities will continue.

Has the NHS made it worse?

Over the last decade, on average, admissions to hospital in better off areas are more likely to come via waiting lists and in poorer areas by emergency. Roughly speaking 60% of admissions are via waiting list in rich areas and 40% in poor areas. Giving priority to waiting lists targets money towards the rich.

Targeting waiting lists also presents a very different management challenge in different parts of the country. If we look at the ratio between emergency admission and elective admissions it varies by a factor of three across the current PCT (Source—publicly available HAS data). It seems probable that this variation is part of the root cause of the pattern of deficits that built up over the decade. A number of studies suggested different reasons for this pattern; obviously poor management must be part of it but it was noticeable that outside London deficits tended to be higher in areas that were better off and less in inner city areas. At the same time as driving the waiting list policy the government also tried to put more money into public health and had an allocation formula that gave more to deprived areas. The three policies simply do not fit together. In the end it was the waiting list policy that came out on top and both public health funds and general budgets in solvent PCTs were raided to pay off the deficits in the other areas. Placating middle class demands for health care was given greater priority than preventing illness and reducing inequalities. For the last decade this has been government policy, there has been considerable success in reducing waiting lists but it is hardly surprising that health inequalities have got worse.

Prof. Rod Griffiths, CBE

About the Author

In the early 1970s secretary of the Socialist Medical Association (now the SHA).

1974–1981 CHC member Central Birmingham

1979–1981 Chair of the Association of CHC for England and Wales

1982–1990 Director of Public Health Central Birmingham

1990–Professor of Public Health University of Birmingham

1993–2004 Regional Director of Public Health West Midlands

2004–2007 President of the Faculty of Public Health

Currently chair National Commissioning Group

ORAL HEALTH INEQUALITIES

Dr John Beale

Whilst oral health has improved in the UK over the past couple of decades unacceptable inequalities remain, with those from the most deprived sections of the community and from some minority ethnic groups having the highest levels of dental disease. These groups are also the least likely to be regular attenders at the dentist. Not only is oral health an integral part of general health but there is also evidence that poor dental health is associated with some other diseases. For example, there are several studies that have demonstrated an association between periodontal disease (poor gum health) and an increase in heart disease, even after other confounding variables such as age, gender and social class are taken into account. Conversely, one of the common complications of diabetes is poor gum health. The most important factor in causing oral cancer is smoking, and this is linked to socio-economic status.

It is therefore important that inequalities in dental health are addressed in any strategy for improving the health of the community. This needs to be considered both with regard to the prevention of poor oral health and also encouraging those with the poorest oral health to seek regular dental care.

Although, no doubt worthy, much health education serves to widen inequalities as it relies on action being taken by the most deprived and excluded groups and often involves adopting more expensive lifestyles such as low sugar, low fat diets. The most cost-effective method of reducing the prevalence of tooth decay is through water fluoridation. All social groups benefit but the most socially deprived sections of the community benefit most and inequalities are reduced. This was addressed in the Association's evidence on primary dental care and it is re-iterated that Ministers should ensure that all PCTs and SHAs review the need for fluoridation without delay.

Numerous studies have shown that dental charges are a barrier to seeking regular dental care. The new contract, in which patient charges for fillings are the same no matter how many fillings are required, may have the perverse incentive of encouraging less well off patients to delay going to the dentist until a number of fillings are needed rather than attending regularly and having one or two fillings in each course of treatment. Many "white collar" workers are salaried and do not lose financially when they visit the dentist. Those on low wages, however, often lose money if they have time off from work. PCTs should ensure that dental services are available at times which are convenient to patients.

Whilst oral cancer can occur in all adult age groups, it is predominantly a disease found in older people, especially heavy smokers. The prognosis is much better when the disease is diagnosed early. Older people are inclined to attend a dentist less often, especially if they have full dentures (itself associated with social status). Removing the financial barrier to seeking regular check-ups would help to encourage more frequent attendance in the groups most likely to have oral cancer and hence facilitate earlier diagnosis. Consideration should be given to providing free dental examination for those aged over 60 years, as it is in Scotland. This age group already have free prescriptions and eye checks and it is difficult to see why dental checks should be different.

Memorandum by the Ophthalmic Public Health Group at the Royal College of Ophthalmologists and The VISION2020UK Primary Care Group (HI 30)

HEALTH INEQUALITIES AND EYE HEALTH IN THE UK

The former reports to the Scientific Committee and Professional Standards Committee of the Royal College of Ophthalmologists and the latter to the VISION2020UK Executive. This is a multidisciplinary group with members from all health personnel delivering eye care at the primary level including Optometrists, Orthoptists, Ophthalmic nurses, General Practice and Ophthalmologists.

1. Both groups strongly endorse broader public health initiatives aimed at improving the public health of the nation, such as campaigns against tobacco consumption and targeting obesity, both of which impact on eye health. Additional impact can be achieved in those campaigns by including blindness as an outcome that can be prevented by avoiding tobacco consumption, excess weight gain, maturity onset diabetes and systemic hypertension. The efficacy of such campaigns, and means of increasing effectiveness, need to be addressed.

2. But we specifically wish to draw the attention of the Health Committee to serious inequalities in eye health arising from the lack of integrated organisation of NHS eye health care; this is a situation set to deteriorate unless relatively simple and potentially cost effective measures are taken to deal with it now.

3. The well established WHO global initiative for the elimination of avoidable blindness by 2020—VISION2020 The right to Sight—asserts the vital importance of primary eye care and integrated eye health services for the prevention of avoidable blindness which is known to constitute 80% of sight loss in the world. This volume is greatest in poorer countries; poverty causes sight loss and sight loss causes poverty. [Holden 2007].

4. What is not apparently recognised is that the same is applicable to the UK. Older people from lower socio-economic groups are more likely to experience sight loss from all the major causes of blindness (cataract, glaucoma, DR and now—we think—AMD) when compared to their wealthier counterparts. Much of this sight loss is preventable, avoidable or at least remediable if people have access to appropriate services. [Evans *et al* 2004].

5. From the inception of the NHS, eye health interventions (apart from the prescription and provision of spectacles) have been delivered at the secondary care level within the Hospital Eye Service which has always been underserved and over subscribed with enormous outpatient volumes and (until recently) long waiting lists for inpatient/daycare treatment. This situation has been allowed to become embedded and endemic in the NHS and is a problem which successive administrations have overlooked, presumably because of the predominance of other major public health priorities. Eye health has never emerged as an issue of concern at the public health or primary care level.

6. At present, primary eye care is distributed in an uncertain and disintegrated relationship between GPs (few of whom have had eye care training because of the secondary care basis of the speciality) and Optometrists who only relatively recently have had a legal status allowing them to do more than identify

deviations from normality. Ophthalmic medical practitioners whose role was perhaps most potentially valuable in the primary care sector are rapidly diminishing in numbers. Emergency departments of hospital eye units continue to carry a heavy component of primary eye care consultations.

7. The Department of Health is currently pushing to provide more community based care especially for chronic eye conditions and the optometric profession is keen to take on this role. Recent legislation on authorisation of prescription of a range of medicines by optometrists will facilitate this development and training is proposed to provide a cadre of optometrists equipped and motivated to manage chronic eye conditions locally. They are being encouraged to bid for the provision of services presumably within the practice based commissioning model. [NHS primary Care Contracting October 2007].

8. The problem is that the public perception of sight tests and the role of optometrists in delivering primary eye care is variable. Poorer and less well educated people are much less likely to seek regular eye examinations. This is because of concern about the cost of spectacles which are set high in order to sustain the viability of optometric practice in a business sector. Optometrists are under pressure, in the current economic environment, to maximise their profits by selling a large range of different products to their clients. This has the potential to engender a level of distrust between the profession and their clients.[Cross *et al* 2007] Another concern is that, as high street businesses, optometric practices are less likely to be located in poorer communities and remote rural locations. The critical issue is that this leads to inequity of eye care provision and as a result, a greater risk of avoidable sight loss among poorer people. [Wormald *et al* 1997]. This contravenes the fundamental tenet of the NHS, equity of access and free health care at the point of delivery. Why is sight loss and the prevention of blindness—one of the most profoundly disabling conditions afflicting mankind—not a fully integrated component of primary care in the NHS?

9. Chronic eye disease is worse in more deprived less well educated communities.[Sommer A *et al.*1991] Research has documented that both glaucoma and diabetic retinopathy—both major causes of preventable but irreversible sight loss in working age groups in the UK—present at more advanced stages with worse prognosis in poorer less well educated individuals.[Fraser *et al.* 2001] We have recently shown poorer less well educated men present much later with visually impairing cataract [Foot *et al.* 2007]. Some black and ethnic minority groups suffer the duplicated risk of both deprivation and increased risk of sight loss such as glaucoma in African and Af rican Caribbean people and both cataract and diabetic retinopathy in people from the Indian subcontinent. [Wormald *et al* 1994, Chaturvedi *et al.* 1998, McKeigue *et al* 1991].

10. With the advent of new and effective therapies for age related macular degeneration, the greatest challenge is for the NHS to provide the sight saving intervention in time before irretrievable sight loss. Regardless of successfully met waiting times targets, treatments will not work if people do not access services at the primary care level. Poorer elderly state pensioners are much less likely to seek early attention for the onset of visual disturbance and are much less likely to visit an optometrist. This is likely to lead to a differential risk of blindness from neovascular AMD in poorer people unless equitably accessible primary eye care can be delivered.

11. Sight loss is commoner in older people and poorer people. Rehabilitation services for those irretrievably vision impaired is very variable across the UK and often poorly accessible. Low vision aids are often only available through the Hospital Eye Service and integrated care is needed in the community. Community based eye care services need integration with social care teams to provide joined up support for the growing number of sight impaired in our population. We know nothing about inequalities in access to rehabilitation services but because they are so variable and often poorly accessible, it is almost inevitable that inequity exists.

12. No eye care Quality Outcome Frameworks and few if any Practice based Commissioning initiatives exist. A proposal for a National Service Framework for Vision has been rejected, though health ministers Rosie Winterton and previously Alan Milburn are signatories to the WHO VISION 2020 initiative. Investment in services and increased outputs, largely from NHS contracts, have been successful in greatly reducing patient waiting times. However funding for pilot eye care pathways has not provided useful evidence to deal with the critical issues in primary eye care delivery. Above all what is needed is an integrated eye care service in the NHS which is not condition specific but provides for all the needs of an ageing population whose needs, demands and expectations of eye care services are set to steadily and consistently increase.

13. We thus make three recommendations

- 13.1. Multidisciplinary eye care teams should plan local eye care services and need training and evidence on which to plan those services—these teams should include Ophthalmologists, Optometrists, Orthoptists, General Practitioners with Special Interest, Ophthalmic Nurses and Public Health Specialists. This is equivalent to the local or district VISION 2020 eye care team as advocated by the WHO Global initiative.
- 13.2. Special provision needs to be made in deprived areas in the UK for multidisciplinary NHS primary eye care centres where people can attend for free testing, cheap spectacles and reliable evaluation for chronic eye conditions and early detection of treatable degenerative disease such as age related macular degeneration. Networks with secondary care must be established for the long term management of chronic eye conditions such as glaucoma and diabetes.

13.3. More prospective research and evaluation is needed especially for community based rehabilitation of the visually impaired which could be coordinated through NHS primary eye care centres.

14. Loss of sight disproportionately affects people from lower socio-economic groups. The current eye care system discriminates against the poor leading to marked inequalities in eye health. The simple and cost effective measures we propose could have a major impact on prevention of avoidable loss of sight and improve the cost efficiency of eye care services nationally. There would be a demonstrable gain in satisfaction of the public in accessing affordable and effective eye care and could ensure that only those that need to be referred are sent to the hospital eye service.

January 2008

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Memorandum by the Joint Epilepsy Council of the UK and Ireland (JEC) (HI 31)

THE CONTRIBUTION OF THE NHS TO REDUCING HEALTH INEQUALITIES

1. INTRODUCTION

1.1 The Joint Epilepsy Council of the UK and Ireland represents 22 epilepsy organisations operating in England, Wales, Scotland, Northern Ireland and the Republic of Ireland. Our mission is to promote improved standards of and access to integrated services in health, education and social care for people with epilepsy and their carers and to increase epilepsy awareness amongst politicians, civil servants, service providers and the general public. The JEC includes representation from patient organisations and the International League against Epilepsy (ILAE) representing clinical specialists with an interest in epilepsy.

1.2 Over 456,000²²⁷ people have epilepsy in the UK. It is the most common serious neurological condition and is a major long-term disability with similar numbers of people affected as insulin dependent diabetes.

1.3 The JEC welcomes this opportunity to submit evidence to the Health Committee relevant to the inquiry into the extent to which the NHS can help to achieve a reduction in health inequalities focussing on:

- (a) The extent to which the NHS can contribute to reducing health inequalities, given that many of the causes of inequalities relate to other policy areas eg taxation, employment, housing, education and local government

²²⁷ Epilepsy prevalence, incidence and other statistics. Joint Epilepsy Council: Leeds. 2005.

- (b) The distribution and quality of GP services and their influence on health inequalities including how the Quality and Outcomes Framework and Practice-Based Commissioning might be used to improve the quality and distribution of GP services to reduce health inequalities,

and include:

- The critical shortfall in clinicians and nurses specialising in epilepsy resulting in a postcode lottery in access to neurological services
- The development of formal clinical networks
- A national programme of epilepsy training for GPs
- A review of the points and categories of QOF for epilepsy
- Consideration of the capacity of practice-based commissioning

2. SUMMARY

2.1 “Services for people with epilepsy fall short of what might be expected in modern chronic disease management . . . Society’s attitudes mean that many people with epilepsy suffer stigma, feel a degree of shame and want to conceal their problem with others. Remove the gloss of civilisation, and greater tolerance and 21st century attitudes to epilepsy are not far removed from those of a century ago. Although the range of treatments available to help people with epilepsy had advanced enormously over the last fifty years, it remains an unfashionable area of clinical practice, which has not attracted the same high profile and professional interest as other chronic diseases such as diabetes. Nor have service planners or policy makers been moved by the plight of people with epilepsy. Since 1953 there have been five government reports which have drawn much the same conclusions about the fragmented and poorly co-ordinated service provision, yet there has been no major change. This suggests a serious failure to act and underlines the ignorance and apathy towards the needs of people with this common disorder.”²²⁸

2.2 In 2008 and in spite of a sixth national report and a Government Action Plan on Epilepsy 2003²²⁹, little has changed.

2.3 The JEC has recently supported a report by the All-Party Parliamentary Group (APG) on Epilepsy “*Wasted Money Wasted Lives; the human and economic cost of epilepsy in England*”²³⁰ which highlights inequalities in healthcare for people with epilepsy. Between 1953 and 2000 there have been five Government reports concerning the provision of epilepsy care. All drew much the same conclusions about the fragmented and poorly co-ordinated service provision. The JEC believes the provision of services for people with epilepsy in England has not substantially improved over the years due to a lack of targets and the absence of any plan (national, regional or local) to address poor levels of knowledge in the clinicians managing the care of many people with epilepsy.

2.4 A number of major recent initiatives have been launched that could positively impact on patient care if effectively implemented, but that implementation is seriously compromised by shortages of neurologists. These include, but are not limited to:

2.3.1 The National Service Framework for Long Term Conditions, focussing on Neurological Conditions

2.3.2 The NICE Clinical Guidelines on the Epilepsies.

2.3 One of the key issues in the area of health inequalities for people with epilepsy as far as the JEC is concerned is the critical shortfall in clinicians and nurses specialising in epilepsy and an under-provision of diagnostic MRI and EEG scanners and staff trained to operate such equipment in many NHS trusts.

2.4 There is evidence that there is a postcode lottery in access to neurological services, and this shortfall is critically affecting the level of care provided to people with epilepsy, including increased levels of epilepsy related deaths.

2.5 A consensus group of experts and the voluntary sector recommended in 2004 that the workforce requirements to implement the NICE Guidelines on epilepsy would require in the short term an increase in the number of epilepsy specialist nurses from 140 to 600. The consensus group also recommends that in the medium term the Government should increase the number of adult neurologists from 352 to 1,400, paediatric neurologists from 75 to 150, learning disability specialists from 340 to 500 and an increase in neuroradiologists from 110 to 160. Clearly NICE Guidelines in this area may be perceived as failing because of current workforce capacity and current resources for training.

2.6 However, “The Department of Health does not have a target for growth in the number of neurologists”—quote from correspondence from the Department, 2005²³¹.

²²⁸ Chief Medical Officer, Sir Liam Donaldson, Epilepsy -Death in the Shadows, Ch 23, Annual Report 2001 (DOH).

²²⁹ NICE Audit of Epilepsy-Related Deaths 2002 (Hanna NJ et al (2002) The National Sentinel Clinical Audit of Epilepsy-Related Death: Epilepsy-death in the Shadows. The Stationery Office.

²³⁰ *Wasted money wasted lives: The human and economic cost of epilepsy in England*, All Party Parliamentary Group on Epilepsy June 2007.

²³¹ Reply to enquiry from Epilepsy Action by Mary King, Customer Service Centre, Department of Health.

2.7 Additionally, the JEC is concerned that this treatment gap has not been addressed by the development of formal clinical networks that can make the best use of the expertise available in a local area.

2.8 Very few GPs recognise epilepsy sufficiently and the JEC would like to see a national requirement for training GPs to deliver quality epilepsy care.

2.9 The JEC recognises that the Quality and Outcomes Framework (QOF), as part of the new General Medical Services Contract, is intended to reward GPs for how well they care for patients rather than simply how many they treat.

2.10 However, witness to the APG Inquiry "*Wasted money wasted lives*" have stated that the QOF indicator performance does not necessarily correlate with adherence to government guidelines and that the QOF for a number of conditions, including epilepsy, measures the basic, not the best care²³².

2.11 The JEC would also like raise concerns about the capacity of practice-based commissioning to commission epilepsy services and also the capacity of practice-based commissioning to adequately involve patient expertise and experience. There is also a serious question of the ability of the new system to effectively monitor access and the quality to services. JEC has concerns that practices may be too small to establish and deliver practice based commissioning effectively. Epilepsy is a good example of a condition where the level of knowledge and expertise of GPs is poor and where significant safeguards would need to be in place before (Chief Medical Officer Annual Report, 2001)²³³.

3. RECOMMENDATIONS

3.1 The JEC believes the quality of GP services for people with epilepsy is inconsistent with too few GPs understanding epilepsy sufficiently, resulting in health inequalities for people with the condition.

3.2 The APG also believes there is a need to include a new category in the QOF with specific inducement to GPs to consider referral of patients whose seizures continue. The introduction of this category needs to be a priority because a reduction in the frequency of epileptic seizures will only be achievable once a patient not responding well to anti-epileptic medication has been referred to tertiary services.

3.3 Concerns have already been stated regarding the competence and capacity for practice-based commissioning relating to epilepsy. There is also the concern that if commissioning is too localised it will not be possible to involve the relevant expertise and views of stakeholders.

3.4 The JEC recommends the development of managed clinical networks as a model for delivery of epilepsy services which can best manage the risks resulting from a serious workforce shortfall in the area of delivery of epilepsy services and ensure a seamless patient journey between GP and hospital. Managed Clinical Networks have been adopted as the model of service delivery in Scotland. Whilst clinical networks significantly reduce the numbers of specialists needed through use of an integrated team of GPs, nurses and a range of specialists, networks cannot be developed without an investment in workforce.

3.5 Whilst epilepsy is part of the GP contract, there has been no national requirement for training GPs to deliver quality epilepsy care in spite of a series of national reports identifying that the knowledge base for epilepsy is particularly weak at a primary care level in comparison with other chronic conditions. The JEC believes each PCT or Health/NSH Board should include epilepsy in its local plans and at minimum, regular epilepsy training for its GPs and an epilepsy register should be mandatory²³⁴.

3.6 The APG Inquiry *Wasted money wasted lives* heard evidence that GPs are vital in carrying out an annual epilepsy review. However, often the review was simply done over the telephone by a practice nurse with no experience or training in epilepsy. A paper, by I Minshall and D Smith²³⁵, published in 2006 revealed that out of 610 people with epilepsy surveyed; only 41% had been seen by a GP in the previous year.

3.7 NICE recommends that all individuals with epilepsy should have a comprehensive care plan that is agreed between the individuals, their family and/or carers as appropriate, and primary and secondary care providers. A survey by Epilepsy Action revealed that 75% of respondents did not have a care plan.

3.8 The Quality Outcomes Framework (QOF) has made a difference to patient care in some practices. However, evidence given to the APG Inquiry *Wasted money wasted lives* suggested "Some of the best care for people with epilepsy cannot be measured, because it is about information, it is about support, and it is about making correct decisions about self-management of the condition"²³⁶.

3.9 The APG recommends that the number of maximum points which GP surgeries can earn under QOF for epilepsy be increased from the current 15 out of a possible 1,000 and that the quality criteria under DOF be revised so that they reflect optimal care as opposed to basic care.

²³² Dr. Henry Smithson, oral evidence, medical practitioners, *Wasted money wasted lives: The human and economic cost of epilepsy in England*, p5.

²³³ The Annual Report of the Chief Medical Officer of the Department of Health 2001, Department of Health.

²³⁴ *Epilepsy, the case for investment*, Joint Epilepsy Council, 2004.

²³⁵ Minshall I, Smith D. The development of a city-wide epilepsy register. *Seizure* (2006) 15, 93–97.

²³⁶ Dr. Henry Smithson, oral evidence, medical practitioners, *Wasted money wasted lives: The human and economic cost of epilepsy in England*, p6.

3.10 In conclusion, epilepsy is an area of health inequality that would benefit from action within the NHS. As the previous quote from the Chief Medical Officer (pg 1) indicates, a significant degree of inequality in this area is the outcome of outdated negative attitudes towards this illness amongst both clinicians and policy makers. Health policy focused on accurately defining and meeting the needs of the individual and addressing inequalities in this area could provide a significant improvement in the treatment of this chronic condition and address inequality.

The Joint Epilepsy Council would welcome the opportunity to expand on this evidence and present oral evidence to the committee.

January 2008

Annex

Members of the Joint Epilepsy Council of the UK and Ireland:

Brainwave—The Irish Epilepsy Association
 David Lewis Centre for Epilepsy
 Enlighten—Tackling Epilepsy
 Epilepsy Action
 Epilepsy Bereaved
 Epilepsy Connections
 Epilepsy Research Foundation
 Epilepsy Scotland
 Epilepsy Specialist Nurses Association
 Epilepsy Wales
 Epilepsy West Lothian
 Fund for Epilepsy
 Gravesend Epilepsy Network
 Gwent Epilepsy Association
 International League against Epilepsy (British Branch)
 The Meath Epilepsy Trust
 Mersey Region Epilepsy Association
 National Centre for Young People with Epilepsy
 National Society for Epilepsy
 Organisation for Anti-Convulsant Syndrome
 Quarriers
 St. Elizabeth's Centre

Memorandum by the British Heart Foundation (HI 32)

HEALTH INEQUALITIES

EXECUTIVE SUMMARY

The British Heart Foundation is the nation's leading charity and is committed to reducing the level of heart related deaths in all UK local authority areas to the current level in South East England or below. To meet this ambitious goal, we have developed a tool to assist staff assess inequalities in heart health and decide how best to tackle them. The tool consists of eight straightforward questions and trains staff to tackle inequalities in one of three ways—either by enacting universal policies that will have a disproportionate impact on high risk groups; modifying mainstream programmes to make them more appropriate; or working with local communities to design and deliver bespoke programmes. We believe a similar approach should be adopted by the NHS to ensure that it has a coordinated approach to tackling inequalities in health. In order for this framework to be effective, it needs to be accompanied by a commitment to training key staff, collecting local data that highlights inequalities and addressing them in a sustainable way using principles of public and population health.

1. As the nation's leading heart charity, the British Heart Foundation (BHF) welcomes this opportunity to submit evidence to this inquiry. The BHF recognises that heart disease is a disease of inequality and that in order to reduce these inequalities it may be necessary to allocate our resources unequally by targeting those most in need.

2. The BHF's commitment to tackle inequalities in cardiovascular disease is reflected in our strategic plan which includes the ambitious aim of reducing the level of heart related deaths in all UK local authority areas to the current level in South East England or below. This will be monitored as a key performance indicator and we will be releasing a statistical report on heart disease and inequalities in mid-February 2008.

3. As the Inquiry's terms of reference point out, many of the causes of heart health inequalities relate to non-NHS factors including taxation, employment and education. A 2006 report from New Zealand underscores the importance of addressing socio-economic factors in order to reduce health inequalities²³⁷. It estimated that socio-economic factors account for about half of the widening gap in mortality between indigenous New Zealanders and European New Zealanders during the 1980s and 1990s.

4. Crucially, the more recent narrowing of mortality inequalities in New Zealand (from 1996 to 2004) may reflect recent narrowing in social inequalities²³⁸. It is thus essential that the Government's Health Inequalities Strategy, due to be launched in March 2008, reflects the need for cross-government initiatives.

5. Having said this, the charity is certain that there is a crucial role for the NHS to play in reducing health inequalities—or at the very least, not making inequalities worse. This is particularly true for inequalities in cardiovascular disease.

6. According to the latest inequalities update from the Department of Health²³⁹, circulatory disease accounts for between 30–35% of the gap in life expectancy between Spearhead Local Authorities and the England population as a whole. Since as much as 80–90% of premature cardiovascular disease (CVD) is preventable^{240, 241}, it stands to reason that successfully tackling inequalities in heart disease will significantly reduce overall health inequalities.

7. The first way the NHS can contribute to reducing health inequalities is by using population health and broader public health approaches to service funding, planning and delivery. These words can be defined in many ways and have different meanings to different people. In this context, the BHF is using the Acheson definition of public health as “the science and art of preventing disease, prolonging life and promoting health through organised efforts of society²⁴²”. Part of effective public health requires a population approach which assesses the health needs of specific population groups. This provides a solid evidence base that will inform decisions.

8. More activity is required to improve the quality, collection and use of socio-economic data (including ethnicity). For example, ethnicity data has recently been included in the QOF Registry. However this currently only relates to the collection of ethnicity data on new patients. In addition, the primary use of this data is to secure income for GP surgeries rather than to inform prevention initiatives. From a population health perspective, this data is both under-collected and underused. A greater commitment to its collection and use would help GPs and commissioners to understand more about the nature and extent of inequalities in their populations.

9. A prerequisite for a strengthened public health service is sustainable and meaningful funding. Despite promising rhetoric, this Government's commitment to public health and prevention services is low compared to other OECD countries. While leading countries spend at least 4% of their total healthcare expenditure on public health, the UK spends less than 2%.²⁴³

10. There is also the growing concern that public health funds have been diverted to pay for burgeoning PCT deficits²⁴⁴. This means serious consideration should be given to both increasing public health funding and ensuring this funding is ring-fenced at local level.

11. The second way the NHS can contribute to reducing health inequalities is by addressing inequalities in access to health prevention and care services. The BHF's commitment to reducing inequalities in access to prevention and care services is underpinned by our use of an Equity Lens. This lens helps our staff decide how they can best address inequalities. Training is provided to all key staff on how to answer the eight questions included in the lens. These questions are:

1. What is the problem you are trying to tackle?
2. Is the problem a greater issue for some population groups?
3. Are there any major differences between identifiable population groups?
4. What might cause these differences?

²³⁷ Ministry of Health and University of Otago (2006). *Decades of Disparity iii: Ethnic and socioeconomic inequalities in mortality, New Zealand 1981–1999*. Wellington. Ministry of Health.

²³⁸ Ministry of Health (2007). *Annual Report for the year ended 30 June 2007*. Wellington. Ministry of Health.

²³⁹ Department of Health (2007). *Tackling Health Inequalities: 2004–06 data and policy update for the 2010 National Target*. London. Department of Health.

²⁴⁰ Yusuf S et al (2004). *Effect of potentially modifiable risk factors associated with myocardial infarction in 52 countries (the INTERHEART Study): case-control study*. The Lancet 364: 937–952.

²⁴¹ Hu, F. (1999). *Findings from the Nurses' Health Study presented at the 72nd Scientific Sessions of the American Heart Association*, Atlanta, GA, November 8.

²⁴² Acheson D (1988) *Committee of Inquiry into the future development of the Public Health Function. Public Health in England*. London: HMSO.

²⁴³ Expert Advisory Panel on Preventative Health Spending. (2007). *Definitions and measures of preventative health spending*. London. Health England.

²⁴⁴ *Public health funds are being raided to pay PCT deficits*. Environmental Health News, 26 October 2007.

5. What is the best way to address these inequalities?
6. Could your initiative unintentionally widen inequalities?
7. If it could widen inequalities is there anything you can do to prevent this?
8. How will you measure whether you have made any difference to the inequalities identified above?

12. To help our staff answer question 5—what is the best way to address these inequalities—we suggest one of three options. We believe these options are equally relevant for the NHS.

13. The first option is to enact universal policies that we know will have a disproportionate impact on high risk groups. The second is to modify mainstream programmes to ensure that they are appropriate for high risk groups. The third option is to work with high-risk groups to develop tailored interventions that meet their specific needs.

14. A universal policy that the charity is supporting that will have a disproportionate positive impact on high risk groups is the use of a single multiple traffic light labelling on the front pack of food products. We believe that, although these labels will be useful for the total population, there is a compelling argument that people with low literacy skills and people for whom English is a second language will find them particularly useful. Since heart disease rates are higher in people with low literacy levels and from certain ethnic groups, we believe that this is an example of a population wide approach that will disproportionately benefit high risk groups.

15. Similarly, the NHS can enact universal policies that will benefit high risk groups the most. An example from the recent past is the implementation of the workplace smoking ban across all NHS buildings including mental health facilities. Initial proposals to exclude mental health facilities from the ban would have widened inequalities because of the high rates of smoking amongst people living with mental illness.

16. Another example of a universal policy that the NHS could implement that would reduce inequalities is to incentivise risk assessments for people at key stages of life. NICE is currently considering the most appropriate risk assessment tool to ensure that the assessment does not underestimate cardiovascular risk in certain high risk populations. Once their decision is made, risk assessments should be a routine part of primary care services.

17. An example of a BHF initiative where we modified a mainstream message to make it more appropriate to high risk groups was our recent *Doubt Kills* campaign to encourage people to dial 999 if they were experiencing chest pain.

18. This award winning campaign featured the image of a man with a belt tightening around his chest along with the caption—*Doubt Kills*. In developing this campaign, the BHF recognised two things. The first is that heart attack rates are higher in South Asian men than in the general population. The second was that the top-line image would not be appropriate for some segments of the South Asian population. As a result, the BHF ran a parallel campaign which used a different media and visual to communicate the same top-line message of *Doubt Kills Dial 999*.

19. The NHS could incorporate the same philosophy in many of its programmes. For example, we know that cardiac rehabilitation programmes are under-represented by South Asian heart patients, particularly women. There is some evidence that South Asian women are put off rehabilitation by the clinical setting, dominance by white, middle class males and focus on exercise. It is therefore reasonable that, in areas of the country with a high population of South Asian, cardiac rehabilitation programmes could be set in community centres and have messages tailored to the needs and interests of South Asian women. And while the BHF welcomes Gordon Brown's recent announcement on vascular screening,²⁴⁵ we are concerned that without careful consideration of how to encourage high-risk population groups to participate, the initiative runs the grave risk of unintentionally increasing inequalities. A consistent challenge of population screening programmes is their inability to attract high-risk groups to participate. This is true both internationally²⁴⁶ and nationally, for example the NHS Breast Screening Programme²⁴⁷.

20. The third option to reducing inequalities is illustrated by the charity's Ramadan campaign. The purpose of this campaign is to encourage Muslims to adopt healthy lifestyles through relating healthy lifestyle message to passages in the Koran. Crucial in its success is the close working relationship that has been developed with local community leaders, particularly imams.

21. The main vehicle for the NHS to work with and through local community groups to reduce inequalities is through public health departments. There are numerous examples of this approach at the local level, unfortunately there are an equal number of examples of programmes that have failed or been discontinued because of a lack of public health resources. As noted above, sustainability of local public health departments must be a key priority of the NHS if it hopes to maximise its contribution to reducing inequalities.

²⁴⁵ <http://www.info4local.gov.uk/documents/publications/628222>

²⁴⁶ Lai Fong Chiu (2003). *Inequalities of access to cancer screening: a literature review*. Sheffield: NHS Cancer Screening Programmes.

²⁴⁷ Rutter, D; L Steadman and S Field (2002). *Final report to NHSBSP: An intervention to increase breast screening uptake*. Canterbury, University of Kent.

22. BHF's Equity Lens is relatively simple and, it could be argued, fails to address the complexity of health inequalities. However we believe that the advantage of its simplicity is that it provides a pragmatic solution for our staff. Our experience is that other more complex tools often disempower staff rather than enable them. We would expect that our methods will gain in complexity as our understanding, experience and skill grows.

23. The NHS should commit to using a tool like the BHF's Equity Lens in all its work. Part of this commitment should include inequalities training for all key staff.

24. Contracts and monitoring frameworks produced by NHS commissioners should require providers to consider how initiatives, particularly mainstream initiatives, will contribute to reducing health inequalities.

25. Returning to our initial point—that many, if not most, of the causes of heart health inequalities relate to non-NHS activities—the NHS is uniquely placed to offer cross-governmental leadership. The NHS should be mandated to ensure that other departments ingrain a culture that sees reducing health inequalities as an important part of their work.

January 2008

Memorandum by Professor Ken Judge, Dean of the School for Health at the University of Bath (HI 34)

HEALTH INEQUALITIES

1.1 The purpose of this note is to comment on some specific aspects of the brief published by the Select Committee.

- The role of Health Action Zones in efforts to reduce health inequalities.
- The potential for NHS Stop Smoking Services to reduce health inequalities.
- The varied and somewhat confusing approach taken in different parts of the UK to the setting of headline targets to reduce health inequalities.
- The importance of recent developments in relation to audit, review and implementation in relation to the infant mortality target in England as demonstrated in a recent review of experiences in Chile, Canada, Sweden and the UK.

2 HEALTH ACTION ZONES

2.1 HAZs were multi-agency partnerships located in 26 areas of England. The first wave of HAZs was launched in 1998 (15 areas) followed by a second wave (11 areas) in 1999. They varied significantly in terms of their population size and organisational configuration, ranging from large conurbations such as Merseyside and Tyne and Wear to largely rural areas such as Cornwall and North Cumbria. They were provided with fairly modest resources (approximately £4–£5 million per year per zone at 2004 prices) but expected to develop local programmes and activities to improve health and reduce inequalities during a seven-year lifespan.

2.2 The three broad strategic objectives of HAZs were: to identify and address the public health needs of the local area; to increase the effectiveness, efficiency and responsiveness of services; and to develop partnerships for improving people's health and relevant services. The largest proportion of initial programmes addressed the determinants of health by promoting healthy lifestyles, improving employment, housing, education and tackling substance abuse. Another important set of activities focused on the health of particular population groups and/or specific health problems. But there was hardly any aspect of population health improvement or community regeneration that at least one of the HAZs was not concerned with in one way or another.

2.3 HAZs were born at a time when anything seemed possible for a New Labour Government desperate to make things work and quickly. But the tide of enthusiasm for change outran the capacity to deliver it. Too many hugely ambitious, aspirational targets were promulgated. The pressure put on local agents to produce "early wins" was debilitating. A sense of disillusionment began to set in relatively early in their lifespan, and HAZs soon lost their high profile as the policy agenda filled with an ever-expanding list of new initiatives to transform public services and promote social justice. By the beginning of 2003, much earlier than expected, they were to all intents and purposes wound up.

2.4 The national evaluation of HAZs focussed on monitoring activity in all 26 zones as well as examining three specific themes within different samples of HAZs: building capacity for collaboration both amongst statutory agencies and with the community; developing the capacity for whole systems change; and tackling health inequalities. One of the main findings was that, although HAZs made little impact in terms of measurable improvement in health outcomes during their short lifespan, they did make a valuable contribution to building partnerships and raising awareness regarding inequalities in health. The study found that the sheer complexity of the initiative and the extent of policy change that HAZs experienced meant that drawing simple conclusions about impact was difficult.

2.5 Part of the problem for HAZs was that they were encouraged to set themselves impossibly ambitious goals to transform the health of their communities. Although modest progress was made with individual programmes and projects, there is no escaping the fact that HAZs did not—probably could not—do what they set out to achieve. But that does not mean that there is nothing of value to learn from their experience.

2.6 The national evaluation of health action zones led by Professor Judge produced a large number of publications including an overall assessment in the form of a book—(M Barnes, L Bauld, M Benzeval, K Judge, M Mackenzie & H Sullivan, *Health Action Zones: Partnerships for Health Equity*, Routledge, Abingdon, 2005)—and two overall summary papers

- L Bauld, K Judge, M Barnes, M Benzeval, M Mackenzie and H Sullivan, “Promoting Social Change: The Experience of Health Action Zones in England”, *Journal of Social Policy* (2005), 34, 3, 427–445.
- K Judge, L Bauld, “Learning from Policy Failure? Health Action Zones in England” *European Journal of Public Health* (2006), 16, 4, 341–344.

Assessment

2.7 The Wanless 2 Review concluded that although “there is often evidence on the scientific justification for action and for some specific interventions, there is generally little evidence about the cost-effectiveness of public health and preventative policies or their practical implementation”. One of the consequences is that policy initiatives are often not thought through with sufficient care, and researchers attempting to evaluate them often spend a great deal of time and effort supporting their development and implementation.

2.8 The HAZ experience supports this view. It clearly demonstrates that there is a need to think more carefully about the focus of such initiatives, their objectives, their timescales, the support that they need both locally and nationally and the space, trust and time that is required to make any kind of sustainable change possible.

2.9 The notion that an injection of relatively modest resources accompanied by guidance—more evangelical than practical—from central government might result in the speedy resolution of major social problems, that had proved largely intractable for generations, would not find so many advocates today as was probably the case a decade ago. But HAZs were put under considerable pressure to demonstrate that they were “making a difference” within a relatively short time period even though, as one contemporary commentator observed, “early hits are not always evidence of accurate shooting”.

2.10 The overwhelming problem—evident in much contemporary policy research—is that the voracious appetite for intelligence by policymakers too often encourages the production of simple descriptions of activity, which are passed off as evidence of “good practice” without adequate discussion of the strengths and weaknesses of what is being presented. While undertaking the evaluation of HAZs we had serious concerns about the pressure to generate and use learning at too early a stage in the cycle of data collection, analysis and reflection. Simply documenting activity, which is frequently demanded and regularly served up, is not evidence of good practice and the growing tendency to pretend that it does yields little more than propaganda. Too many users of policy research still expect clear answers about impact when a more realistic product of evaluations is that they contribute to a process of enlightenment about highly complex processes that are interpreted by different actors in multiple ways.

3. NHS STOP SMOKING SERVICES

3.1 A national programme of smoking cessation treatment was introduced in England in 2000. These evidence-based services are supporting large numbers of smokers in their quit attempts. Yet, whatever the success of the treatment services in reducing smoking prevalence as a whole, there has been no national monitoring of the social distribution of service recipients and the impact on health inequalities. What does exist is a target to reduce smoking prevalence among “routine & manual” groups from 31 per cent (at baseline in 2002) to 26 per cent or less by 2010, and there has been strong encouragement from the Department of Health that local services should focus their efforts on the most disadvantaged smokers. Indeed, there is now a clear expectation that smoking cessation services can make a significant contribution to achieving the 2010 life expectancy health inequality target, notwithstanding the disappointing trends in recent years.

3.2 A group led by Professor Judge conducted a national evaluation of NHS Stop Smoking Services and many of the main results were published in a special issue of the peer-review journal *Addiction* published in 2005:

<http://www.blackwell-synergy.com/toc/add/100/s2>. Subsequently an attempt was made to assess whether treatment services do have a realistic role to play in reducing inequalities in smoking prevalence as a whole, and to estimate the size of any beneficial impact. A paper by Bauld, Judge & Platt, published in *Tobacco Control* in December 2007, uses small area estimates of smoking prevalence and national monitoring data for NHS stop smoking services to compare changes over time between relatively advantaged and disadvantaged areas in England. A summary of the paper is set out in the box below.

ASSESSING THE IMPACT OF SMOKING CESSATION SERVICES ON HEALTH INEQUALITIES IN ENGLAND: AN OBSERVATIONAL STUDY

Background

The paper assesses the extent to which services have made a contribution to reducing inequalities in smoking between 2003–4 and 2005–6. Synthetic estimates of baseline smoking prevalence data for local authorities were obtained from ONS. These were compared with national monitoring data about the numbers of smokers in receipt of services and the proportion who self-report quitting at four weeks. The social distribution of service recipients and quitters was compared with estimates of smoking prevalence to assess impact on inequalities. Comparisons were made between officially-designated disadvantaged areas (the Spearhead Group) and others.

Main results

Short term cessation rates were lower in disadvantaged areas (52.6%) than elsewhere (57.9%) ($p < .001$), but the proportion of smokers being treated was higher (16.7% compared with 13.4%) ($p < .001$). The net effect was that a higher proportion of smokers in the most disadvantaged areas reported success (8.8%) than in more advantaged areas (7.8%) ($p < .001$). The impact of services on conventional measures of inequality depends on assumptions about relapse rates. Using the evidence-based assumption that three-quarters of short-term quitters will relapse, the absolute and relative rate gaps between spearhead areas and others fall by small but statistically significant amounts from 5.2 and 1.215 (CIs: 1.216, 1.213) in 2000–2 to 5.0 and 1.212 (CIs: 1.213, 1.210) in 2005–6.

Conclusion

NHS stop smoking services have probably made a modest contribution to reducing inequalities in smoking prevalence. To achieve government targets, however, requires both the development of more innovative cessation interventions for the most addicted smokers and action to ensure that other aspects of tobacco control policy make a larger contribution to inequality goals.

4. NATIONAL HEALTH INEQUALITY TARGETS

4.1 England, Northern Ireland, Scotland and Wales share a common commitment to reducing health inequalities and have set explicit targets in areas such as life expectancy, cancer mortality, long standing illness and smoking prevalence. However, many of the targets leave much to be desired in terms of their limited conceptual scope, methods and approaches. At one level this might be regarded as relatively unimportant. The mere fact of having health inequalities targets is laudable. But because the UK has been in the vanguard of research and policy development to reduce health inequalities, a critical appraisal of the strengths and weaknesses of the approaches adopted in the different home countries is timely. Such a critique is contained in a paper to be published later this year.

— L Bauld, P Day and K Judge, “Off Target: a critical review of setting goals for reducing health inequalities in the UK”, *International Journal of Health Services*, in press.

4.2 Following a description of the health inequalities targets used in the four home countries, the paper focuses on experiences in England and Scotland as examples of contrasting approaches to target setting and describes progress towards meeting targets in each. The paper then outlines key emerging issues in relation to developing targets and measuring progress, including conceptual dilemmas, biased reporting, implementation failure and statistical fallacy.

4.3 The paper demonstrates that the process of setting and monitoring health equity targets is more complex than might be expected. Despite the fact that experience in the different parts of the UK is as advanced as anywhere in Europe it identifies both conceptual and operational dilemmas that ought to be more clearly understood and acted upon.

4.4 Of course, whatever the problems with targets we cannot renounce policy priorities and nor should we stop measuring progress towards them. Rather we must be aware that assessing progress in tackling health inequalities is complicated because of target imperfections and that the solution involves changes to both the construction and use of targets.

4.5 The paper acknowledges that there are many different ways to specify health equity goals and to establish monitoring systems to review and report on progress towards meeting them. What is most important is that targets make sense in the policy context where they are employed, that they are closely monitored and that the results are disseminated for public scrutiny. On balance, though, we believe that the most sensible approach may be similar to that originally advocated in Scotland but ignored by the Scottish Executive in actually setting targets. There may also be considerable merit in a broadly similar approach being developed by the Norwegian government in its *National strategy to reduce inequalities in health*.

4.6 Both examples recommend monitoring a basket of indicators to gauge progress in tackling inequalities but without specifying targets in terms of precise levels of reduction within specified timeframes. Whatever approach is adopted, however, it is crucial that health inequality goals should be linked to indicators that can be updated on a regular basis, that monitoring data are widely disseminated, and that regular reports should be produced by government agencies explaining what progress, or lack of it, has been made.

5. RECENT DEVELOPMENTS IN RELATION TO THE INFANT MORTALITY INEQUALITIES TARGET IN ENGLAND

5.1 Infant mortality has been widely used as an index of equity and human development, but while there are many studies that have described and seek to account for variations between countries in average rates of infant mortality less attention has been paid to differences in social inequities in infant deaths within nations. A recent paper prepared for an international meeting sponsored by the DH attempts to redress this imbalance by examining variations in policy responses to perceptions of social inequities in infant mortality in Canada, Chile, Sweden and the United Kingdom (with a particular but not exclusive focus on England). A copy of the paper is attached and it can also be found on the DH website: http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Healthinequalities/DH_077951

5.2 The main aim of the paper is to provide background information about the ways in which concerns about inequities in infant mortality are identified and measured and the policy responses associated with them in the four countries.

5.3 The paper begins by setting the experience of the four countries in a wider international context and shows that they all have good or very good infant and under-5 mortality rates. This introductory material also provides data about the extent of inequalities in under-5 mortality for a group of poorer countries for which data are easily available from the WHO (2007).

5.4 The paper then turns to a description of patterns and trends in inequalities in infant mortality and some other birth outcomes, distinguishing between the use of routine data in some settings and research evidence in others. The next section suggests that some distinctive approaches about policies to reduce inequalities can be identified in the four countries. In Chile and the UK there is a strong emphasis on the use of targets. Canada relies heavily on a comprehensive set of categorical programmes. Possibly only England, and perhaps Wales, has what might be described as a clear strategy and action plan being put in place. Whereas Sweden is the best documented example of a strong reliance on a universalist philosophy.

5.5 A number of emerging issues are identified next. The first concerns the focus of interventions. Has the right balance been struck between targeted health care interventions and addressing the wider social determinants? The second issue relates to the use of targets. Do we now have enough practical experience of the use of targets as one of the mechanisms to tackle health inequalities to ask more searching questions about the ways in which they are used? The third concern relates to the ways in which health inequalities are measured and monitored. Many different approaches are used even within a single country, and this makes comparisons difficult. Do we have enough collective experience now to make stronger recommendations about the best approach to defining inequalities and monitoring progress in reducing them?

5.6 Finally, the paper highlights the weakness of the evidence base about inequalities in infant mortality and recommends the need for more research into areas such as the effectiveness of interventions, the nature of the problems facing ethnic minorities and the possible role of different social welfare regimes in achieving desired outcomes.

5.7 There is no convincing evidence that any country has found a clear solution to reducing inequalities in infant mortality. In terms of the quality of the policy process, however, England appears to be leading the way internationally. The implementation plan recently published by the DH, and the detailed analysis of the lack of progress that preceded it, represent very substantial steps forward.

January 2008

Memorandum by Clinical Solutions (HI 35)

HEALTH INEQUALITIES

A. INTRODUCTION

A.1 Clinical Solutions welcomes the opportunity to respond to the Health Select Committee's inquiry into health inequalities.

A.2 Clinical Solutions is the world's leading provider of decision-support software for clinicians. We have designed and provided the computer programmes which underpin NHS 24 and NHS Direct, as well as in healthcare services around the world—in Australia, New Zealand, Norway, Scotland and the United States. All of our products have been delivered to the NHS on time, and on budget.

A.3 We are committed to constructive working with the Government and the NHS to help communities tackle health inequalities and believe that technology has the potential to make a significant contribution. Experience has shown us that new technologies, such as clinical decision support software, and telehealth and telecare systems, can transform the quality and accessibility of health services and deliver improvements in information and care for patients.

A.4 Clinical Solutions' response focuses on two of the inquiry's major themes:

- The extent to which the NHS can contribute to reducing health inequalities
- The ways in which improved access to primary and urgent care services can assist the NHS in tackling health inequalities

B. EXECUTIVE SUMMARY

B.1 Health inequalities are caused by a wide variety of factors, many of which are outside the control of the NHS and social care services. However, inequalities in health outcomes are exacerbated by the problems those in deprived communities encounter in accessing health services.

B.2 The greater integration of primary and urgent care services—such as NHS Direct, GP out-of-hours services, walk-in centres and Accident and Emergency (A&E) departments—can help improve access to health and social care services for those in deprived communities. We share the NHS Next Stage Review's aim of establishing a single telephone number for urgent care services in order to provide a universal and consistent access point for patients.

B.3 Walk-in centres, in particular, have—and should continue to—play a role in making healthcare services more accessible to hard-to-reach groups. By their nature, walk-in centres provide services more convenient and less intimidating than traditional primary care services, as well as providing drop-in access to health services for patients unregistered with a GP.

B.4 With the burden of long-term conditions relatively higher in deprived areas, any strategy for tackling health inequalities must also put in place effective plans for their management, which fully harnesses the potential of telecare and other forms of health-related technology, coupled with the support and knowledge of health professionals. The Department of Health's Whole System Demonstrator pilots—currently ongoing—will provide valuable experience to inform the health inequalities strategy.

B.5 Tackling health inequalities requires commissioners in Primary Care Trusts (including practice-based commissioners) to recognise and imitate the variety of healthcare models now working successfully across the country, and—in particular—to fully utilise the potential for technology both to deliver improved access to healthcare services for those in equal need, as well as to deliver cost savings to the NHS.

C. THE ROLE OF THE NHS IN REDUCING HEALTH INEQUALITIES

C.1 Inequalities in health outcomes are caused by a wide variety of personal, socioeconomic and environmental factors. These include employment status, the quality of housing, the environment more generally, education and genetic factors attached, for example, to race.

C.2 Although many of these factors are outside the control of the NHS and social care services, it has long been recognised that the availability of good healthcare varies inversely with the needs of the population served.²⁴⁸ This reinforces and exacerbates the differences in health outcomes caused by the factors outside the control of the NHS and social care.

C.3 Any effective strategy for tackling health inequalities must therefore ensure that health services deliver—at the least—equal access to health services for those in equal need. Indeed, this view has been underscored recently by the Secretary of State for Health, who explained in a speech of 12 September 2007 that, “we must improve access to decent healthcare for people from deprived areas”.²⁴⁹ In addition, the NHS Next Stage Review noted, in its interim report, that a comprehensive strategy for reducing health inequalities must, “ensure fair access to NHS services for everyone”.²⁵⁰

C.4 In order to ensure fair access to primary care services, a proportionately greater effort needs to be made in deprived areas vis-à-vis areas less deprived: evidence suggests that a significantly higher proportion of people living in deprived areas report putting off a visit to see their GP because of inconvenient hours²⁵¹; whilst areas with significant black and minority ethnic populations report high levels of inappropriate access to urgent care services—such as A&E departments—because of a lack of awareness of other points of access to primary care.²⁵² This results not only in a poorer standard of care, but is also cost-inefficient: each attendance at an A&E department costs, on average, £87, compared to an average consultation cost at a walk-in centre of just £27.²⁵³

²⁴⁸ *The Lancet*, The inverse care law, 27 February 1971.

²⁴⁹ Alan Johnson, Speech to the New Health Network, 12 September 2007.

²⁵⁰ Department of Health, *Our NHS: our future*, 4 October 2007.

²⁵¹ King's Fund, *Inverse care law*, 21 June 2001.

²⁵² For example, the Bangladeshi community in Tower Hamlets. Cited in Alan Johnson, Speech to the New Health Network, 12 September 2007.

²⁵³ *Hansard*, 1 November 2006, Col. 484WA.

D. SIMPLIFYING ACCESS

D.1 This evidence of inappropriate use of urgent care services in deprived areas underlines the need for a simple way to access them. To this end, we welcome the commitment contained in the NHS Next Stage Review's interim report to explore, "the introduction of a single three-digit number in addition to the emergency services number 999".²⁵⁴ As the supplier of the software which underpins NHS Direct—through which nurses assess the level of care needed by a patient and direct them to the most appropriate service—we see at first-hand the great potential for savings to be made by the integration of telephone healthcare services with GP out-of-hours services and other urgent care settings in this way. Indeed, in Australia, we have assisted in realising this potential (see case study, below).

Case study: GP Assist

Our GP Assist service provides out-of-hours support to GPs throughout the state of Tasmania. All out-of-hours calls by patients are routed through our GP Assist centre, staffed by a small team of doctors and nurses.

Here, assisted by our CS Teleguides—software, they provide advice and support to callers and arrange the most appropriate care for them—including, where appropriate, a GP going to their home. Of all the calls made to GP Assist, just 7% end up being referred to a local out-of-hours GP, and almost three-quarters (73%) result in reassurance or advice being delivered over the phone. The caller's GP is provided with a full report the next day. This has had a secondary benefit of encouraging GPs to remain in rural communities, safe in the knowledge that they will be called upon out-of-hours only when absolutely necessary.

D.2 We would ask the Committee to consider the ways in which a single telephone point-of-access for urgent care services can contribute to tackling health inequalities by making primary care services more accessible in deprived areas.

E. EXPANDING WALK-IN CENTRES

E.1 Over the last few years, walk-in centres have also proved effective in enhancing access to primary care services for hard-to-reach groups, such as young men and homeless people.²⁵⁵ A recent Department of Health-commissioned study found that 35% of people believe that to be able to walk into NHS health centres on the high street whenever you want would be a "big improvement"²⁵⁶, and this need is even greater in deprived localities, where fewer GPs tend to work despite incentives designed to encourage them to do so.²⁵⁷

E.2 The Department of Health has recently reiterated its view that increasing the number of routes into primary care—in part, through walk-in centres—increases the chances of delivering services at a time and a place which suits the needs of patients.²⁵⁸ Co-locating walk-in centres and A&E departments in inner-city areas can also realise significant efficiency gains for the NHS, with the cost of an attendance at a walk-in centre (£27) comparing favourably with that of an attendance at an A&E department (£87).²⁵⁹

Case study: Tooting Walk-in Centre

Situated in an inner-city area with a significant black and minority ethnic population, the Tooting Walk-in Centre—which uses the paperless software developed by Clinical Solutions—sits alongside the fully equipped A&E department at St George's Hospital in South London. Its location ensures that it eases pressure on the A&E unit: people visiting A&E with minor conditions are instead directed to the Walk-in Centre, and almost three in five visitors to the Walk-in Centre said that—if it did not exist—they would have gone to A&E or other local health services instead.

E.3 We share the view of the Department of Health that the continued expansion of walk-in centres will help to tackle health inequalities, and we are particularly encouraged by the moves mooted in the Next Stage Review to create "health centres" combining both health and social care services.²⁶⁰ Since the users of social care services are among the most vulnerable groups in society—and are more likely to experience the problems of housing and a lack of employment which are also contributory factors to health inequalities—the co-location of social care and health services will facilitate access for these groups to the NHS.

²⁵⁴ Department of Health, *Our NHS: our future*, 4 October 2007.

²⁵⁵ Department of Health, *Tackling health inequalities: consultation on a plan for delivery*, 23 August 2001.

²⁵⁶ Department of Health, *Our Health, Our Care, Our Say*, 30 January 2006.

²⁵⁷ King's Fund, *Inverse care law*, 21 June 2001.

²⁵⁸ Alan Johnson, Speech to the New Health Network, 12 September 2007.

²⁵⁹ *Hansard*, 1 November 2006, Col. 484WA.

²⁶⁰ Department of Health, *Our NHS: our future*, 4 October 2007.

F. LONG-TERM CONDITIONS MANAGEMENT

F.1 Any strategy for tackling health inequalities must include as a core component ways in which long-term conditions may be tackled. There are clear links between deprivation and individual long-term conditions: a King's Fund study looking at admissions for Chronic Obstructive Pulmonary Disease (COPD) medical admissions in the UK between 2000 and 2002, for example, found that the rate of hospital admission for COPD rises as deprivation increases. Further analyses found that 31% of such admissions could be attributed to deprivation.²⁶¹ The Long Term Conditions Alliance estimates that three in five hospital beds are at any point occupied by people with long-term conditions²⁶², and in deprived areas this burden—other things equal—is likely to be considerably higher.

F.2 We share the view of the Department of Health that the effective management of patients with long-term conditions in the community can diminish the number of emergency bed days considerably, and therefore result in an improved quality of care and improved health outcomes.²⁶³ We are of the view that the more widespread use of telecare technology can help to deliver care of greater cost- and clinical-effectiveness. Call volumes to NHS Direct, for example, vary during the course of the day, affording nurses the opportunity to make outbound calls at times of low demand, in order to actively mentor, coach and help patients with long-term conditions to self-manage more effectively their conditions. With the advice nurses deliver over the phone complemented by decision-support software tailored to individual patients, technology such as this allows the needs of patients with long-term conditions to be addressed in a very precise way.

F.3 As a key delivery partner in the Department of Health's Whole System Demonstrator pilot in Newham—which aims to show how comprehensive and holistic approaches to the care of patients with long-term conditions, making full use of electronic assistive technologies (coupled with the support and knowledge of a trained health professional) can deliver significant improvements in the quality and efficiency of care—we are actively involved in the development of such systems in deprived areas. We hope that the Department of Health will make full use of the results of the pilot in order to assist in its development of the strategy for tackling health inequalities.

G. SUMMARY

G.1 Tackling health inequalities requires commissioners in Primary Care Trusts (including practice-based commissioners) to recognise and imitate the variety of healthcare models now working successfully across the country, and—in particular—to fully utilise the potential for technology both to deliver improved access to healthcare services for those in equal need, as well as to deliver cost savings to the NHS.

G.2 We hope the Committee finds this evidence of use, and we would be glad to submit further evidence if required.

January 2008

Memorandum by the Association of Directors of Adult Social Services (HI 36)

HEALTH INEQUALITIES

1. INTRODUCTION

1.1. The Association of Directors of Adult Social Services (ADASS) represents Directors of Adult Social Services in Local Authorities in England. As well as having statutory responsibilities for the commissioning and provision of Social Care, ADASS members often also share a number of responsibilities for the provision and/or commissioning of housing, leisure, library, culture arts and community services within their Councils.

1.2. The Association is able to bring together tremendous breadth, depth and accumulated experience on all issues covering managerial policy and professional activities of Adult Social Care departments and cross cutting issues with Children's Services departments and NHS organisations.

1.3. Our members are jointly responsible through the activities of their departments for the well-being, protection and care of thousands of vulnerable people and for the promotion of that well-being and protection through the use of direct services as well as the co-ordination of, and liaison with the NHS, voluntary agencies, private companies and other public authorities.

²⁶¹ King's Fund, *COPD medical admissions in the UK: 2000–01–2001–02*, August 2004.

²⁶² http://www.lmca.org.uk/pages/about_ltc.html

²⁶³ Department of Health, *Our Health, Our Care, Our Say*, 30 January 2006.

1.4. Our members have leadership responsibilities in Local Authorities to promote local access to services and to drive partnership working to deliver better outcomes for local populations. They participate in the planning of the full range of Council Services and influence Health Service planning through formal and informal Local Strategic Partnership arrangements.

2. BACKGROUND

2.1. Despite increased national prosperity, wider opportunity and increasing life expectancy for all, the gap in life expectancy between and within local authority areas and infant mortality between different social groups remains a major challenge. The shared priority for healthy communities and reducing health inequalities agreed between central and local government makes tackling health inequalities a priority for local authorities, and is included as part of the comprehensive performance assessment. It is recognised that reducing health inequalities requires National and Local leadership and action.

2.2. Data in respect of the gaps in life expectancy and infant mortality between different social groups is increasingly well known. Understanding cause and taking action to prevent gives a significant challenge. A Public Health perspective suggests that the reasons for health inequality arise from the following:

- inequalities in opportunity—poverty, family, education, employment and environment etc.
- inequalities in lifestyle choices—smoking, physical activity, food, drugs, alcohol and sexual activity
- inequalities in access to services for those who are already ill or have accrued risk factors for disease(health inequality)

Actions to address inequalities will need to address all three dimensions of root cause.

2.3. The identification of Spearhead Areas (Local Authorities with the worst health and deprivation) with additional support and funding has been welcomed. It is also recognised that health inequalities often arise in communities and families from other disadvantaged groups. They are not confined to Spearhead Areas. Those most at risk are often in touch with Social Care Services within all Local Authority Boundaries.

2.4. The importance of Health and Social Care partnerships has been affirmed in many recent publications. (E.g. Our Health, Our Care, Our Say- Department of Health Jan 2006—The Future of Health and Adult Social Care: A Partnership Approach for Wellbeing). These documents provide a unifying vision for integrated health and adult social care. They also recognise Local Authorities' local leadership role for health and wellbeing, advocating partnerships working in localities between Councils and Primary Care Trusts (PCTs) building on Local Area Agreements and Local Strategic Partnerships as key mechanisms for joint planning and delivery.

2.5. The importance of developing such plans in the context of a shared understanding of local need has also been recognised in the Local Government and Public Involvement in Health Act (2007). This places a duty on upper-tier Local Authorities and PCTs to undertake a Joint Strategic Needs Assessment (JSNA) of their population(s). The legislation places the accountability for producing the JSNA with the three key Directors: the Directors of Adult Social Services, of Children's Services and of Public Health. Guidance recently published states that the JSNA should inform Local Area Agreements and the forthcoming Sustainable Community Strategy. Both these strategies will be central to local areas commissioning responses and action to address health inequalities.

2.6. The JSNA will require Local Authorities (LA) and Primary Care Trusts (PCTs) to engage with local communities and provide evidence of effectiveness of intervention. These will be core requirements which are welcomed by our members. Recognition of the engagement with individuals and communities as "primary partners" is seen as a significant factor which will address inequality in the longer term. This approach has been highlighted in the Department of Health document "Choosing Health" which is underpinned by the core principles: Choice, Personalisation and Working Together.

3. ROLE OF THE DIRECTOR OF ADULT SOCIAL SERVICES

3.1. Section 6 of the Local Authority Social Services Act 1970 was amended following the introduction of the Children Act 2004. The amendment requires a local authority with social services responsibility in England to appoint an officer as the Director of Adult Social Services (DASS).

3.2. In May 2006 the Department of Health issued Best Practice Guidance on the role of the Director of Adult Social Services. The intention of this guidance is to create, within each Council with social services responsibilities, a post with a strategic responsibility for the planning, commissioning and delivery of social services with all adult client groups.

3.3. The DASS has a leading role in delivering the Government's wider vision for social care, including delivering better integration between a range of agencies responsible for supporting people with care needs and promoting wellbeing. The postholder champions the wellbeing of adults in the community and in residential care, provides professional leadership and delivers the cultural change necessary to implement person-centred services and to promote partnership working.

3.4. The DASS is responsible for supporting and promoting social inclusion and wellbeing by engaging with mainstream services and other local initiatives to support, build and enable community capacity and reduce inequalities. The DASS role is central in encouraging services to be designed around the needs of individuals, rather than dictated by organisational or professional boundaries- the DASS provides a specific focus on adults and this involves a role in championing the needs of adults that goes beyond the organisational boundaries of adult social care. There is a clear link to close working with PCTs and in particular Directors of Public Health, Commissioners and Providers in joint work to reduce health inequalities.

In this context, the Association is pleased to submit the evidence below to the Health Select Committee Inquiry into Health Inequalities.

4. THE INQUIRY- HEALTH INEQUALITIES

4.1. *The Extent to which the NHS can contribute to reducing health inequalities, given that many of the causes of inequalities relate to other policy areas eg taxation, employment, housing, education and local government;*

4.1.1. ADASS recognises that the NHS has a significant contribution to reducing health inequalities. The contribution is both direct and indirect through influence. The scope of NHS interface is with individuals, with communities, with local areas, with regions and a national level. The role is in leadership and the development of strategy across all sectors but it is recognised that the leadership in respect of inequalities of opportunity(viz. para 2.2) are shared with central government and local strategic partnerships. Shared responsibilities and accountabilities exist to ensure that the wider determinants of health and health promotion are realised within the overall strategies and responses of all government funded services.

4.1.2. In relation to inequalities and opportunity, the NHS has a significant if indirect role in reducing poverty, promoting family life, engaging in education, promoting employment and ensuring a sustainable environment. The NHS is a key partner through primary care and public health in relation to the development of local strategies to ensure action is taken in areas of need. The role of the NHS in developing the economic environment of local communities and neighbourhoods is perhaps under developed. The recognition of the NHS as a major employer and procurer of services would enable a closer examination at local levels of the impact of decisions and promotion of opportunity. The role of the NHS in working alongside local government to develop sustainable environments and healthy workforces is also an area for further development.

4.1.3. The role of the NHS in developing positive lifestyle choices has received increasing national attention with positive examples of significant progress particularly through the work of Spearhead Areas. The role of Public Health alongside local government in developing local strategy, influencing political decision making at local levels and engaging local overview and scrutiny committees has raised the awareness and given opportunity for impact. The increasing role of Directors of Public Health often through joint appointments with Local Authorities, has influenced local decision making in high risk areas such as smoking cessation, increasing physical activity, drug and alcohol strategies, sexual health and more recently the measures being taken to reduce obesity.

4.1.4. There is further scope for more targeted action following the publication of local Joint Strategic Needs Assessments. Current initiatives are often funded through short term targeted funding (eg NRF) and are at risk of "quick fix" thinking in relation to health inequalities. Experience shows that impact is often linked to sustained and long term action. The opportunity for Joint Strategic Needs Assessments to influence commissioning decisions of mainstream services is a welcome opportunity to drive targeted mainstream action to improve public health, primary and secondary care outcomes.

4.1.5. The recent change of funding to local government through Area Based Grant would give the opportunity for the Department of Health to provide health improvement funding as part of the Area Based Grant rather than through separate mechanism in the NHS. Alternatively, ring fenced NHS funding for health inequalities could be earmarked alongside the Area Based Grant to ensure maximum impact is achieved through local commissioning decision making and the "pooling" of or "alignment" of budget and activity across the NHS and Local Government.

4.2. *The Distribution and quality of GP Services and their influence on health inequalities, including how the Quality and Outcomes Framework and Practice-based Commissioning might be used to improve the quality and distribution of GP services to reduce health inequalities.*

4.2.1. The "under doctoring" of poorer areas is highlighted in the State of Healthcare report 2007 and reports there are 18% fewer GPs than in the wealthier areas. The Association recognises that in some local areas there is some accelerated development of practice based commissioners taking a broader population perspective and addressing the preventable healthcare needs of their populations. However, it is suggested that these are in the minority and that progress in practice based commissioning and partnerships with social care, local government and the wider public sector are under developed.

4.2.2. Contracts with GPs continue to be focussed around high list sizes and payment for defined interventions. It is the submission of the Association that the initial focus of practice based commissioning has been concerning the interface between primary care and secondary care and has not yet actively pursued the potential for partnership with wider public service. The interface has been promoted via PCTs and public health with little direct contact with practices and practice based staff except on matters of individual need.

4.2.3. There is considerable further scope for Practice Based Commissioners/GPs working alongside communities and with local strategic partnerships. The barriers to development of closer partnership arrangements are acknowledged, not least the pressures of single-handed GPs and low staffing ratios within areas of high deprivation. Direct influence on the independent contractor role is also challenging in respect of the GP contract. The considerable national emphasis on waiting time targets and secondary care interface may also have influenced the speed of partnership development for practice based commissioners. The Association would recommend a further review of the financial incentives and accountability arrangements for GPs working in areas of high deprivation with the acceleration of options for directly employed practitioners and /or new incentivisation and support for areas where under-doctoring is a significant feature. Contracts should include a requirement of partnership working to prevent the emergence of gaps in service or duplication of effort.

4.3. *The effectiveness of public health services at reducing inequalities by targeting key causes such as smoking and obesity, including whether some public health interventions may lead to increases in health inequalities; and which interventions are most cost-effective*

4.3.1. The research base of evidence concerning the impact of public health intervention as a direct cause and effect of health improvement is still under developed. It is suggested that much of the research into inequalities is descriptive of the problem and exact measures to say what works in reducing inequalities remains unclear. The many and various causes and determinants of ill health in communities makes it difficult to apply rigorous research methodology. Continued investment into developing the research base focussed on how to make a difference in health inequalities would be welcomed.

4.3.2. The Department of Communities and Local Government (DCLG) have Health Inequalities as part of their 2007 Beacon Scheme. The scope of the criteria for judging local authorities and health communities to be Beacons in tackling and reducing health inequalities include leadership vision and strategy, community and customer engagement and empowerment, actions taken through addressing key determinants, promoting healthy lifestyles and secondary care enhanced public health programmes. Examination is made of the quality of partnerships, the actions taken to address equality and diversity and the measurement of outcomes. Decisions regarding the outcomes of Beacon applications have not yet been made. However, wide dissemination of local government and the DCLG best practice would be helpful in partnership with DH and NHS organisations

4.4. *Whether specific interventions designed to tackle health inequalities such as Sure Start and Health Action Zones, have proved effective and cost-effective;*

4.4.1. The Association offers no specific evidence on this issue.

4.5. *The success of NHS organisations at co-ordinating activities with other organisations, for example local authorities, education and housing providers, to tackle inequalities; and what incentives can be provided to ensure these organisations improve care*

4.5.1. NHS organisations have committed considerable energy and activity in the last ten years to work in partnership to address health inequalities. As has already been highlighted, the cause or effects as identified in poverty, unemployment, inadequate housing, poor education attainment are all addressed through key policy directives of all government departments. There is a shared ownership through local government and public service partners to address these matters and the vehicles of Local Strategic Partnerships, and latterly Local Area Agreements have been key delivery arrangements. The effectiveness of the NHS has been affected by the complexity of local arrangements including co terminosity (or its absence), and county arrangement where two tier authorities exist. It is the Associations submission that the recent merger of PCTs has considerably eased joint working on a wide range of issues. Previously the relatively small size of PCTs made it difficult to influence the larger populations of local authority decision making.

4.5.2. Public services are incentivised through strong performance management frameworks and the move to cross government and cross service collaboration through Local Area Agreements supported by the new public service agreements and performance framework. Development of shared performance targets is a considerable incentive in improving and prioritising the reduction of health inequalities. However, as submitted elsewhere in this memorandum, the emphasis in recent years to short term funding and quick fixes are a barrier to the long term interventions required to tackle health inequalities in the most intransigent areas. A single funding source for local strategic partnerships pooled and shared in relation to prioritisation

of the key issues to address would be welcomed. As reported in section 4.1.5 the possibility of combining a DH funding stream alongside the DCLG area Based Grant would be a positive approach across all local government not just the Spearhead Areas.

4.6. The effectiveness of the Department of Health in co-ordinating policy with other government departments, in order to meet its Public Service Agreement targets for reducing inequalities

4.6.1. The engagement of the Department of Health in the development of the Local Area Agreement and the performance framework has been beneficial in supporting local areas to address the reduction of inequalities within their programmes and priorities. The Association welcomes the dual function of Directors of Public Health at Government Regional Office and Strategic Health Authority levels and particularly welcomes the strengthening of social care within regional offices in the near future. A shared cross government initiative to highlight best practice areas for reducing health inequalities would be welcomed.

4.7. Whether the Government is likely to meet its Public Service Agreement targets in respect of health inequalities

4.7.1. The Association shares the concerns outlined in the State of Healthcare report 2007 which highlights the inequalities experienced for those with Mental Health problems and those with Learning Disabilities. The priority focus for the NHS in respect of secondary care waiting time targets continues to disadvantage those with more specialist and on occasion high cost interventions. Whilst the recent announcement to transfer the commissioning of Learning Disability services to local government through Social Services authorities is welcomed, there is a risk that the NHS will reduce further its prioritisation of services and actions to reduce inequality in this high risk group. The role of primary care in reducing mental ill health through health promotion, particularly in disadvantaged communities has struggled to receive the attention warranted. The drive to reinforce the importance of both these disadvantaged groups would be welcomed.

January 2008

REFERENCE DOCUMENTS

Commissioning Framework to improve Health and Wellbeing
<http://www.dhn.org.uk/dhn/briefing-detail.jsp?id=1398&md=0§ion=briefing>

Update on Tackling Health Inequalities
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_062903

The State of Health Care Report 2007
<http://www.dhn.org.uk/dhn/briefing-detail.jsp?id=1678&md=0§ion=briefing>

Guidance on the role of the Director of Adult Social Services
http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_4116629

IDeA Beacon Application Brochure 2007
<http://www.beacons.idea.gov.uk>

Our Health Our Care Our Say
http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Modernisation/Ourhealthourcareoursay/Browsable/DH_4130638

Guidance on JSNA
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081097

White Paper: Choosing Health, Making Healthy Choices Easier
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4094559

Memorandum by the National Institute for Health and Clinical Excellence HI 37)

HEALTH INEQUALITIES

1. EXECUTIVE SUMMARY

1.1 NICE guidance helps to improve public health and make access to healthcare and opportunities to improve health more equal across the country. Our approach to health inequalities includes:

- supporting and monitoring the implementation of NICE guidance so as to eliminate variations in access resulting from uneven uptake;
- a particular focus on reducing health inequalities in our public health guidance; and
- systems to ensure that, where it can, NICE guidance promotes equitable access to treatment, prevention and health promotion.

1.2 As variations in implementation of NICE guidance have implications for equity, we support local implementation by providing a range of forward planning and costing tools and advice, and through a team of regional implementation consultants who talk directly to NHS trusts and local authorities.

1.3 The healthcare standards are an important factor in promoting uptake of guidance. It is essential for NICE's role—and in the interests of a high quality, cost-effective health service with an effective role in reducing health inequalities—that new arrangements for healthcare regulation from April 2009 reinforce the importance of compliance with all categories of NICE guidance.

1.4 NICE's public health guidance programme covers a range of health topics, risk factors, population groups, settings, and generic processes of potential importance in tackling health inequalities. It has revealed substantial gaps in evidence about cost effectiveness and the differential impact of interventions associated with factors such as social class, ethnicity, gender, age, and deprivation.

1.5 In the course of developing guidance NICE makes research recommendations to fill evidence gaps. There are around 400 of these so far, including 39 public health research recommendations. It is important for NICE, the NHS and government health policy that there is a more rapid response to these research recommendations.

1.6 Upcoming public health guidance on complex interventions will present research challenges going beyond the health sector. A strategic approach involving collaboration by the Department of Health with other government departments will be needed to fill gaps in the evidence base about multi-sectoral action to deal with public health problems.

1.7 It is important for the work of NICE and the NHS in promoting equality that a concern for identifying the impact of interventions across the various dimensions of equality identified in the government's equalities review is integral to research and data-gathering activity within the national research and health information strategies.

1.8 An annex to this memorandum prepared on behalf of the Public Health Interventions Advisory Committee (PHIAC), the advisory body responsible for producing NICE's public health intervention guidance, discusses important lessons from PHIAC's work that are relevant to several of the questions posed in the Committee's terms of reference.

2. ABOUT NICE

2.1 The National Institute for Health and Clinical Excellence (NICE) is the organisation responsible for providing national guidance, and setting standards, on the promotion of good health and the prevention and treatment of ill health.

2.2 NICE produces guidance in four areas of health:

- public health—guidance on the promotion of good health and the prevention of ill health for those working in the NHS, local authorities and the wider public and voluntary sector
- health technologies—guidance on the use of new and existing medicines, treatments and procedures within the NHS
- clinical practice—guidance on the appropriate treatment and care of people with specific diseases and conditions within the NHS
- interventional procedures—guidance on whether procedures used for diagnosis or treatment are safe enough and work well enough for use in England, Wales and Scotland.

2.3 NICE guidance helps to improve public health and make access to healthcare more equal across the country. Although the NHS is NICE's main audience, NICE guidance increasingly makes recommendations aimed at local government, providers of adult social care and children's services, and other public sector agencies.

3. HEALTH INEQUALITIES AND NICE'S ROLE

3.1 A commitment to reducing inequalities in access to healthcare and other opportunities to improve health is integral to NICE's role of providing national guidance. Our approach to health inequalities has the following elements, which are discussed in more detail in the next sections:

- Support for NHS organisations in implementing NICE guidance, and systems to monitor progress in eliminating variations in access to services resulting from uneven uptake locally;
- A particular focus on reducing health inequalities in NICE's public health guidance;
- Systems to ensure that, as far as possible, NICE guidance promotes equality—in relation to race, disability, sex, sexual orientation, religion or belief, and age—in access to care and opportunities for improving health, as well as helping tackle health inequalities associated with socioeconomic status.

3.2 The annex to this memorandum has been prepared on behalf of the Public Health Interventions Advisory Committee (PHIAC), the advisory body responsible for producing NICE's public health intervention guidance. It discusses important lessons from PHIAC's work that are relevant to several of the questions posed in the Committee's terms of reference.

3.3 Progress in tackling health inequalities depends to an important degree on the scale and quality of the public health evidence base. Much of our submission is a discussion of the continuing weakness of the public health evidence base and why urgency in the public health research effort is vital for NICE's work and for the general effort to tackle health inequalities.

4 ELIMINATING VARIATIONS IN IMPLEMENTATION OF NICE GUIDANCE

4.1 There is uneven implementation of NICE guidance, even though a direction on funding makes local provision of treatments recommended in technology appraisals more or less mandatory, and the healthcare standards include expectations of adherence to NICE clinical guidelines and public health guidance.

4.2 An Audit Commission study identified weaknesses in local financial management as the most significant barrier to implementation (Audit Commission 2005).²⁶⁴ However, the reasons for delay in uptake need further investigation and we are currently investigating the part played by a range of factors, including, for example, the level of deprivation in PCT areas.

4.3 Provision in a PCT area of treatments or services recommended by NICE guidance does not of course guarantee that everyone who might benefit from an intervention gains access to it or takes it up. However, the persistence of variations in uptake does have implications for equity, and so we have significantly expanded our support for local implementation in the last couple of years. We now provide a range of tools and searchable databases, which can all be found on our website. These are designed to enable NHS trusts to include implementation of NICE guidance in their forward planning, manage the financial implications, monitor progress on implementation, share experience of implementation, and, as appropriate, commission evidence-based care. We also have a small team of regional implementation consultants whose job is to provide a more tailored service of support, advice and problem solving to the local NHS and local authorities.

4.4 The current healthcare standards require healthcare organisations to comply with NICE guidance: technology appraisals and guidance on interventional procedures in the case of the core standards; and clinical guidelines and public health guidance in the case of developmental standards. This, in conjunction with the role of the Healthcare Commission, is an important factor in promoting uptake. The decision to create a new health and social care regulator from April 2009 and related changes to the NHS's performance management framework mean that there will shortly be a reconsideration of the role and form of healthcare standards and nature of regulation. We suggest to the committee that it is essential for NICE's role—and in the interests of a high quality, cost-effective health service with an effective role in reducing health inequalities—that new arrangements reinforce the importance of compliance with all categories of NICE guidance.

²⁶⁴ Audit Commission (2005) Managing the financial implications of NICE guidance. London: The Audit Commission.
www.audit-commission.gov.uk/reports/NATIONAL-REPORT.asp?CategoryID=ENGLISH%5E574&ProdID=CC53DDFE-42C8-49c7-BB53-9F6485262718

5. NICE GUIDANCE AND HEALTH INEQUALITIES

5.1 A concern with equitable access to treatment and care is central to all NICE guidance, but, as envisaged in the 2004 *Choosing health* white paper, NICE's public health guidance has a particular focus on improving population health and well-being and narrowing health inequalities.

5.2 Our public health guidance falls into two categories: public health intervention guidance, which makes recommendations on relatively simple, often face-to-face, interventions that help to reduce people's risk of developing a disease or condition or help to promote or maintain a healthy lifestyle; and public health programme guidance dealing with broader and generally more complex interventions aimed at promoting good health and preventing ill health in the population, and narrowing health inequalities.

5.3 So far we have published six items of intervention guidance. These cover smoking cessation, smoking cessation in the workplace, physical activity, sexually transmitted infections and teenage conceptions, substance misuse, and school-based alcohol interventions. A further nine items of guidance are in development. These cover various dimensions of mental health and well-being, smoking by children, needle exchange, immunisation, and improving access to services in disadvantaged areas.

5.4 We have published programme guidance on behaviour change, and a further 11 topics are in development, covering, for example, various aspects of child health, the health of children in care, the management in the workplace of long-term sickness and absence, and smoking and physical activity.

5.5 In addition, we published in 2006 a clinical guideline on the prevention and treatment of obesity. This was jointly developed by the former National Institute for Clinical Excellence and Health Development Agency (HDA), and covers a very wide spectrum of clinical and public health interventions.

5.6 All NICE guidance includes an analysis of gaps in the evidence. In the case of public health, these gaps are invariably substantial and confirm the continuing validity of the Wanless report's findings on the dearth of evidence about the cost effectiveness of public health interventions (Wanless 2004).²⁶⁵ They also highlight the lack of topic-specific evidence on the differential impact of interventions associated with factors such as social class, ethnicity, scale of deprivation or disadvantage, and other factors.

5.7 For example, in the case of smoking, the NICE guidance on brief advice to encourage smoking cessation identified a lack of evidence on the effectiveness of the intervention in relation to age, gender, socioeconomic status and ethnicity. Our obesity guidance found little evidence on the effectiveness of multi-component interventions among key at-risk groups (such as young children and families and black and minority ethnic groups), vulnerable groups (such as looked-after children and young people, lower income groups and people with disabilities) and people at vulnerable life stages (such as women during and after pregnancy and people stopping smoking). This guidance also recommended that future research should collect sufficient data to assess how the effectiveness of the intervention varies by age, gender, ethnic, religious and/or social group.

5.8 Our guidance on the generic principles of behaviour change—applicable to the problems of smoking and obesity as to all other public health risk factors—found that evidence about cost effectiveness was lacking, particularly in relation to sub-groups in the population such as 19–30 year-olds, low-income groups and particular ethnic and disadvantaged groups. It also stated that few studies of behaviour change interventions addressed the comparative effect on health inequalities, particularly in relation to cultural differences.

5.9 Despite limitations in the evidence, our public health guidance has been able in most cases to recommend interventions for both effectiveness and cost effectiveness. In the case of the latter, and where sufficient data for modelling purposes has been available, the estimated incremental costs of a QALY gained have been within a range well below the NICE acceptability threshold of £20,000–£30,000.

5.10 We recognise that, by stimulating the use of new or improved treatments and services, NICE guidance may result in a widening of the social class health gap as a result of better initial uptake by the people in higher social class groups, who tend to be better informed and adept at navigating the healthcare system. Local implementation strategies geared to ensuring as far as possible equitable access for those whom the intervention is intended to benefit are key in counteracting this effect. Policy developments on commissioning for health and well-being, including the recent Department of Health guidance on joint strategic needs assessment by PCTs and local authorities, are important in this regard.

5.11 As already noted, evidence about effectiveness in reducing health inequalities for specific public health interventions is frequently lacking. However, where appropriate we integrate into our recommendations evidence about generic processes likely to help in tailoring interventions and targeting them at disadvantaged groups and other sub-groups in the population—for example, partnership working among agencies, rigorous needs assessment, consultation with and participation by recipients of the intervention, monitoring of impact, and evaluation.

²⁶⁵ Wanless D (2004) *Securing good health for the whole population*. London: HM Treasury.
www.hm-treasury.gov.uk/consultations_and_legislation/wanless/consult_wanless04_final.cfm

5.12 We are in addition producing guidance about particular generic processes of this kind. This guidance is intended for use in conjunction with guidance on specific risk factors, population groups, and settings as a means of achieving a sharper focus on health inequalities. Examples of this are forthcoming guidance on community engagement and on improving access to services in disadvantaged areas through proactive case-finding and retention. The former will build on known associations between community development approaches and health improvement; and the purpose of the latter is to increase statin use and uptake of smoking cessation in disadvantaged areas, thus contributing to reductions in premature death from cardiovascular disease and lung cancer.

6. FILLING THE EVIDENCE GAPS

6.1 One of NICE's functions is that of identifying clinical and public health research priorities arising from evidence gaps identified in the process of developing guidance and promoting them to research funding bodies. Each piece of NICE guidance therefore includes recommendations for research considered to be important in informing the next review of the guidance (usually after a period of three to four years).

6.2 These research recommendations are of strategic importance in that they emerge from a uniquely robust and systematic sifting process; they relate by definition to the priorities of the NHS because they have arisen from clinical and public health topics that have been referred to NICE in the first place; and they are intimately connected to the NHS reform objective of achieving value for money through cost-effective treatment, care and public health practice.

6.3 Research recommendations from 2004 onwards are freely available to all parties interested in health research on the NICE website. As of June 2007 there were 384 recommendations arising from all categories of guidance. Although NICE took on responsibilities for public health relatively recently, there are already 39 public health research recommendations (including those in the obesity guidance).

6.4 We have welcomed changes in the organisation and focus of health research following the Department of Health's *Best research for best health strategy* (DH 2006)²⁶⁶ and the Cooksey review (Cooksey 2006),²⁶⁷ including greater involvement of NICE in research governance arrangements. We also have a "direct access" arrangement with the National Institute for Health Research's Health Technology Assessment (HTA) programme for taking forward a small number of agreed "essential" research priorities. Nonetheless, competing demands for research funds mean that as yet few NICE research recommendations have resulted in commissioned research projects.

6.5 This indicates that, despite some progress in raising the profile of public health research, much more remains to be done, particularly given the government's ambitions to reduce health inequalities, raise the level of spending on prevention and health promotion nearer to the OECD average, as pledged in the 2006 white paper, *Our health, our care, our say*, and get the NHS on a trajectory towards Wanless's "fully engaged scenario". In this context it is worth reminding ourselves of the baseline position: the UK Clinical Research Collaboration's analysis of UK health research spending found that only 2.5% of research spending was on prevention of disease and conditions and promotion of well-being (UKCRC 2006).²⁶⁸ We suggest to the Committee that it is important both for NICE and the NHS that the research infrastructure responds rapidly to NICE's research recommendations.

6.6 A further research challenge will become apparent over the coming months and years as the volume of NICE public health programme guidance increases. This guidance will often be about complex, multi-sectoral interventions aimed at public, private and voluntary sector agencies, including but going beyond the NHS—for example, encompassing the various local agencies involved in local strategic partnerships (LSPs). Consequently, evidence gaps and related research recommendations will cover policy fields outside the conventional remit of healthcare research.

6.7 Some of these research recommendations will be about the need to evaluate policies and programmes aimed at changing features of the broader social, economic and physical environment that conditions the health behaviour and choices of individuals, families and communities.

6.8 We suggest to the Committee that there is a need for a strategic approach involving collaboration by the Department of Health with other government departments in developing joint programmes to fill gaps in the evidence base about multi-sectoral action to deal with public health problems. The most obvious lead-partners would be the Department for Communities and Local Government (DCLG) and the Department for Children, Schools and Families (DCSF), but with the involvement as appropriate of the Department of Transport, the Home Office and others.

²⁶⁶ Department of Health (2006) *Best research for best health—a new national health research strategy*. London: Department of Health.

www.dh.gov.uk/en/PolicyAndGuidance/ResearchAndDevelopment/ResearchAndDevelopmentStrategy/DH_4127109

²⁶⁷ Cooksey D (2006) *A review of UK health research funding*. London: HM Treasury.

www.hm-treasury.gov.uk/independent_reviews/cooksey_review/cookseyreview_index.cfm

²⁶⁸ UKCRC (2006) *UK health research analysis*. London: UK Clinical Research Collaboration.

www.ukcrc.org/publications/reports.aspx

6.9 Finally, as already noted, NICE guidance identifies gaps in evidence about the impact of interventions on sub-groups in the population, such as people from black and minority ethnic groups or people in different age groups. This is generally because of failures to investigate such impacts in clinical trials and other evaluations. It also identifies gaps in data from surveys and routine information collection in the NHS and elsewhere in the public sector about the distribution among population sub-groups of health and ill health, risk factors, use of and access to services, and of the impacts of clinical and public health interventions.

6.10 The government's Equalities Review (Equalities Review Panel 2007)²⁶⁹ found that health inequalities data were not collected for the purpose of understanding the impact on group inequalities, and there was no continuous and systematic recording or analysis of ethnicity, disability, sexual orientation or religion or belief. In response to the review, the Office for National Statistics carried out a review of equality data and has made over 20 recommendations directed at itself and other government bodies with the aim of improving the accessibility and presentation of data across the range of equality characteristics (National Statistics 2007).²⁷⁰

6.11 NICE is committed to promoting equality and eliminating discrimination in relation to race, disability, sex, sexual orientation, religion or belief, and age through its guidance. Furthermore, the operating framework for 2008–09 has made promoting equality a priority for the NHS. We suggest to the Committee that it is important for NICE's work on health inequalities and for frontline organisations that a concern for identifying the impact of interventions across the various dimensions of equality is integral to research and data-gathering activity within the national research and health information strategies.

NICE

January 2008

Annex

The Public Health Interventions Advisory Committee (PHIAC) and its work on addressing Health Inequalities

1. INTRODUCTION

1.1 PHIAC is the independent public health advisory committee of NICE which deals with NICE's public health intervention guidance. Membership is multi-disciplinary, comprising professionals and practitioners (specialists and generalists), representatives of the public, community groups and technical experts drawn from the NHS, local government, universities, the voluntary sector and the general public. It meets once a month and has been in existence since November 2005. Much of its work has been concerned with activities in the NHS. There are a number of important lessons from the work of PHIAC which will be of relevance to the Select Committee.

1.2 The nature of its work means that PHIAC has considered a vast amount of evidence on the effectiveness and cost effectiveness of public health interventions across a wide range of topics. We therefore believe that we are well placed to provide to the Select Committee a balanced view on the extent to which evidence based guidance to the NHS is possible, how it is likely to influence the NHS's capacity to contribute to the reduction of inequalities, and how this capacity might be enhanced in the future.

1.3 PHIAC's role is to consider and interpret evidence on the effectiveness and cost effectiveness of all public health interventions. It formulates recommendations to NICE on their use in the NHS, local government and the broader public health arena in England. It has a particular interest in reducing health inequalities and considering the impact of interventions on the pattern of health inequalities. At the centre of its concern is the familiar public health conundrum. This is that in Britain we have experienced decades of overall health improvement at population level, but at the same time the health inequalities gradient has remained constant or got worse. The reason for this is that in a developed country like Britain universal services (such as the National Health Service) do not have universal effects. Universal services have differential effects, with the better off benefiting disproportionately. The factors which lead to general health improvement—improvements in the environment, good sanitation and clean water, better nutrition, good health service provision, high levels of immunization, good housing—do not necessarily reduce health inequity. This is because the determinants of good health are not necessarily the same as the determinants of inequities in health (Graham & Kelly, 2004). In order for the inequalities gradient to shift in a more equitable direction, the ways in which interventions can be targeted and universal systems made more usable for the relatively disadvantaged, and the ways in which different sectors in the population respond to interventions needs to be central to the research, policy and planning processes. PHIAC attempts to take these factors into account in its deliberations.

²⁶⁹ Equalities Review Panel (2007) *Fairness and freedom: the final report of the Equalities Review*. London: The Cabinet Office. <http://archive.cabinetoffice.gov.uk/equalitiesreview/>

²⁷⁰ National Statistics (2007) *Review of equality data*. London: Office for National Statistics. www.statistics.gov.uk/about/data/measuring-equality/default.asp

2. *The extent to which the NHS can contribute to reducing health inequalities, given that many of the causes of inequalities relate to other policy areas eg taxation, employment, housing, education and local government*

2.1 PHIAC recognizes the critical importance of so-called “upstream” influences such as income, education, employment and the material environment in generating and maintaining inequalities in health. Nonetheless it considers that the evidence shows that the NHS has a role to play, both in delivery of its own services and by working in partnerships in others. In the public health guidance produced by NICE we have sought to make evidence based, cost effective guidance on how the NHS might do this in specific areas. However, the NHS is not currently compelled to implement this guidance. The Select Committee might consider recommending that the public health guidance issued by NICE must be implemented in the NHS.

3. *The distribution and quality of GP services and their influence on health inequalities, including how the Quality and Outcomes Framework and Practice-based Commissioning might be used to improve the quality and distribution of GP services to reduce health inequalities*

3.1 PHIAC recognizes the potential importance of primary care in reducing inequalities in health. Much of our guidance to date has related to primary care. We have noted that the incentives systems currently in use do not specifically reward those who work to reduce inequalities in health and in some cases may lead to increases in inequalities. We believe that there is potential for incentives schemes, which have a generic evidence base of effectiveness, to be better focused on reduction of inequalities.

4. *The effectiveness of public health services at reducing inequalities by targeting key causes such as smoking and obesity, including whether some public health interventions may lead to increases in health inequalities; and which interventions are most cost-effective*

4.1 The assessment of effectiveness and cost-effectiveness of public health interventions is the central task of PHIAC. We are concerned that, as a general rule, the introduction of health promotion measures, particularly those based on information giving or requiring active participation by the public, may lead to increases rather than decreases in inequalities. We have tried to take this in to account in developing our guidance.

5. *Whether specific interventions designed to tackle health inequalities, such as Sure Start and Health Action Zones, have proved effective and cost-effective*

5.1 We welcome the evaluations of these, where they have been done. However, we note that, in many cases, they were introduced in a way that precluded rigorous evaluation, even though alternative methods of introduction would have allowed evaluation without delaying introduction. In addition we note that many of these interventions would not be expected to be effective or cost effective for a considerable period. Furthermore, assessment of cost effectiveness needs to take all relevant costs and savings into account.

5.2 We recommend that more rigorous methods of evaluation accompany innovations such as these.

6. *The success of NHS organizations at co-ordinating activities with other organizations, for example local authorities, education and housing providers, to tackle inequalities; and what incentives can be provided to ensure these organizations improve care*

6.1 PHIAC is aware of examples of good practice in areas of the country but believes that there is undesirable inconsistency which is likely to increase inequalities in health. We consider that partnership working is an important element of NHS work and have made a number of evidence based recommendations in our guidance to this effect.

7. *The effectiveness of the Department of Health in co-ordinating policy with other government departments, in order to meet its Public Service Agreement targets for reducing inequalities; and*

8. *Whether the Government is likely to meet its Public Service Agreement targets in respect of health inequalities*

8.1 PHIAC has not conducted a review of the targets, but we wish to make a more general observation. The evidence we have considered in different topics indicates that, regardless of the targets, health inequalities are deeply ingrained in our society. We consider that evidence based public health guidance can make an important contribution to service implementation to address health inequalities and to national and local policymaking which directs and supports service implementation.

9. *Development of the evidence base*

9.1 We have been struck by the limited evidence base which is directly applicable to the UK and so to the NHS. The lack of evidence in public health in general is even graver when considering inequalities in health. Much of the evidence we consider is from other countries, particularly the US. The lack of progress on tackling inequalities in health reflects in part a lack of knowledge on how they may be altered. If inequalities in health are to be tackled effectively it is essential for the evidence base to be developed. This will require a concerted and sustained effort from funders, researchers and practitioners.

9.2 Much evidence could be obtained at relatively little cost by improved data collection and analysis within the NHS and with its partners. In addition, a requirement to evaluate new interventions introduced in the NHS, including a requirement to assess their effect on inequalities in health (ie their differential effectiveness and cost effectiveness) would allow the evidence base to be developed whilst not paralyzing innovation.

10. *Using the existing evidence base*

10.1 We consider that the existing evidence base is under-used, partly because of an inappropriate emphasis on particular types of research, such as clinical trials. Our experience at PHIAAC has been that a wide variety of research and information can inform service development. What is lacking is the capacity and sometimes the will to develop the use of this information to inform local and national decision-making. We recommend that this capacity is further developed at national and local level.

11. CONCLUSION

11.1 As noted above, PHIAAC considers that, despite the challenges of the evidence base and the need to strengthen it, there is potential to make evidence based recommendations to the NHS on the reduction of inequalities in a range of areas. PHIAAC is pleased to be contributing to this work but believes that the resources devoted to this are currently grossly insufficient and are limiting what the NHS can achieve.

REFERENCE

Graham, H & Kelly, M P (2004) Health inequalities: concepts, frameworks and policy. London: Health Development Agency. <http://www.nice.org.uk/page.aspx?o=502453>

Memorandum by Bowel Cancer UK (HI 38)

HEALTH INEQUALITIES

This submission from Bowel Cancer UK to the Health Select Committee's inquiry on health inequalities is based on a recent Bowel Cancer UK report entitled *The Bowel Cancer Screening Programme: A progress report on the roll-out of screening in England* which was published in November 2007.

This report evaluated the impact of the screening programme on patient care, and made a number of recommendations concerning equality of access to screening services, diagnostics, treatment and support.

1. INTRODUCTION

1.1 Bowel cancer is the third most common cancer in the UK and the second most common cause of cancer death. One in 20 women and one in 18 men will develop the disease during their lifetime. However, it is one of the most treatable of all cancers and is curable if caught in the early stages.

1.2 The National Bowel Cancer Screening Programme for England was rolled-out in July 2006 and is the first screening programme of its kind for both men and women. It is designed to detect the signs of bowel cancer early in people with no symptoms through the distribution of home test kits by post to people aged 60–69.

1.3 There is strong evidence that of the 16,000+ deaths in the UK per year from bowel cancer more than 2,500 of these could be reduced through screening.

1.4 The programme works by distributing test kits to eligible people at home, which needs to be posted back to a laboratory for analysis. Although the kit does not diagnose cancer itself, the result can determine whether a follow-up examination of the bowel is necessary.

1.5 It is expected that once the screening programme has been fully rolled-out by 2009 there will be over 90 screening centres across England managed by five regional screening hubs.

2. INEQUALITIES EXIST IN THE ROLL-OUT OF SCREENING ACROSS THE UK

2.1 Bowel cancer screening is currently being rolled-out in England and is expected to be fully implemented by 2009 for 60–69 year olds. The age range will be extended upwards to include 70–75 year olds after 2010.

2.2 However, in Scotland, Wales and Northern Ireland, bowel cancer screening is being rolled-out for people aged between 50–74, which will create an inequality in the provision of screening within the UK.

2.3 While Bowel Cancer UK has welcomed the Government's commitment to raise the age range for screening in England from 2010, we believe the age range should be expanded to include those aged over 50 to bring it fully into line with the devolved nations.

3. REGIONAL VARIATIONS IN UPTAKE MUST BE TACKLED TO REDUCE INEQUALITY OF ACCESS

3.1 Evidence from the report (page 12) showed that there were regional variations in the uptake of screening. While some degree of variation may be due in part to differences in the date each screening hub commenced operations, the Department of Health should examine why such disparities exist.

3.2 Regional differences in the way screening is promoted, and the method by which test kits are dispatched and managed, should be investigated to identify if lessons can be learned from those hubs whose response rates are highest.

3.3 NHS services should be incentivised to improve levels of uptake to reduce regional variations to minimal levels. A possible mechanism for doing this would be to include screening within the scope of Payment by Results.

3.4 Patients who receive an abnormal test result are referred for a bowel examination at a screening centre, usually by way of a colonoscopy. There is currently a significant variation in colonoscopy uptake rates (page 15) and further research must be undertaken to identify the reasons why these vary so widely across the various screening centres.

4. VARIATIONS BY GENDER AND ETHNICITY

4.1 Recent evidence shows that uptake of screening was only slightly higher in women compared to men (page 20). However, in a review of the screening pilot programme, evidence showed that the variation was more marked at 56.2% for women and 47.7% for men. It is essential that the screening programme—which is the first to target men—pre-empt any indication that a gap is opening-up in the uptake of bowel cancer screening through regular audits of gender uptake.

4.2 The review of the screening pilot also identified that uptake in testing was lower among those living in areas with a high proportion of people living from the Indian Sub-continent. People from this ethnic group may warrant targeting in future screening rounds. It will be important to involve external stakeholders in planning this process, such as Bowel Cancer UK.

4.3 Bowel Cancer UK is committed to raising awareness of screening, and of the disease generally, amongst at risk and hard to reach groups. This includes younger people, who are often believed to be too young to have bowel cancer; people from ethnic minorities; people with mental health issues; and those living in deprived or isolated areas. In 2008, the charity will be undertaking a screening awareness raising initiative amongst ethnic minority groups in the Midlands, sponsored by the Amgen Foundation.

4.4 The spearhead group of Primary Care Trusts responsible for narrowing gaps in health outcomes in England's most deprived area should also adopt strategies to ensure that bowel cancer screening is used as a tool for addressing health inequalities within their boundaries.

5. REDUCING INEQUALITIES ACROSS THE PATIENT PATHWAY

5.1 Effective screening is only the first step towards improving the early detection and treatment of bowel cancer. Once bowel cancer or pre-cancerous symptoms have been identified, a patient will enter into a treatment pathway which will involve a range of health services and health professionals.

5.2 Charity Cancerbackup's concept of a "Patient Passport" for cancer patients having treatment could be adopted for those who have been identified with bowel cancer through the screening programme. A "Screening Passport" could be introduced which would give these patients a clear idea of what is happening to them and when in terms of their pathway. Implementation of the passport across the UK would ensure equity in the provision of information to patients on their treatment regime.

5.3 Multidisciplinary teams have been shown to be very effective in managing the treatment pathway for cancer patients. It is crucial that specialist nurses are kept in post to meet the demands of the screening programme on hospital services. Reductions in specialist nurse provision across the UK could open-up gaps in patient support which could widen regional health inequalities.

5.4 Reduced waiting times and speedy access to surgery and radiotherapy are major factors in effectively treating bowel cancer. As the screening programme identifies more people with cancer and pre-cancerous symptoms, there will be greater pressure on these services. The Department of Health must ensure that proper monitoring of health service capacity is put in place to ensure patients identified with cancer through screening are effectively and equitably treated.

5.5 After 50 years of just one drug—5FU—being available for bowel cancer patients, there has been a significant increase in the number of new treatments available for bowel cancer, including chemotherapy, oral IV treatments and the biological agents. Unfortunately, current evidence shows that these treatments are often denied to patients in the UK unless they take part in a clinical trial, pay for them privately, or travel abroad to get them. This may be due to a range of factors, including negative or developing NICE guidance, NHS funding shortfalls, perverse incentives in commissioning, or the commissioning policies of different PCTs. Policy makers must take action to ensure health service mechanisms operate in the most effective way possible so that access to the best available treatments can be maximised, including reviewing the methodology for the NICE appraisal system to make it work better for cancer.

January 2008

Memorandum by the Global Health Advocacy Project (HI 39)

HEALTH INEQUALITIES

THE CONTRIBUTION OF THE NHS TO REDUCING HEALTH INEQUALITIES

The Committee will examine the extent to which the NHS can help to achieve a reduction in health inequalities, particularly through primary care and public health services. The inquiry will focus on:

- The extent to which the NHS can contribute to reducing health inequalities, given that many of the causes of inequalities relate to other policy areas eg taxation, employment, housing, education and local government;
- The distribution and quality of GP services and their influence on health inequalities, including how the Quality and Outcomes Framework and Practice-based Commissioning might be used to improve the quality and distribution of GP services to reduce health inequalities;
- The effectiveness of public health services at reducing inequalities by targeting key causes such as smoking and obesity, including whether some public health interventions may lead to increases in health inequalities; and which interventions are most cost-effective;
- Whether specific interventions designed to tackle health inequalities, such as Sure Start and Health Action Zones, have proved effective and cost-effective;
- The success of NHS organisations at co-ordinating activities with other organisations, for example local authorities, education and housing providers, to tackle inequalities; and what incentives can be provided to ensure these organisations improve care
- The effectiveness of the Department of Health in co-ordinating policy with other government departments, in order to meet its Public Service Agreement targets for reducing inequalities; and
- Whether the Government is likely to meet its Public Service Agreement targets in respect of health inequalities.

The extent to which the NHS can contribute to reducing health inequalities, given that many of the causes of inequalities relate to other policy areas eg taxation, employment, housing, education and local government;

1. The Department of Health must oppose proposals to charge vulnerable migrants, including failed asylum seekers, victims of trafficking and undocumented migrants, for primary care services. Introducing charges will effectively deny access to healthcare for affected individuals, with a resultant increase in health inequality. Migrants have a range of health needs, and should ideally register with a general practitioner when they arrive in the UK to ensure that they have access to primary care.

2. If the proposals are adopted, primary care regulations will be brought into line with those governing hospital care, and those not considered “lawfully residents” in the UK will longer be entitled to freely access most primary care services.

3. In 2004 a similar change was made to the regulations governing access to hospital care. One example of the consequences of the 2004 changes in regulation is as follows:

“A man who has been diagnosed as suffering from pulmonary carcinoma presented at XXXXX seeking treatment. He was unsure of his immigration status, but the hospital contacted the Home Office for clarification and was told that he had two failed asylum claims. He was refused treatment

by the hospital and it was suggested he return to his own country to seek treatment. His GP has refused to a request to deem this immediate and necessary care, also suggesting he go home to seek care”²⁷¹.

4. The rationale behind these proposals is that they will save money and discourage “health tourism”. However, the notion of large-scale health tourism remains unproven. In 2005, Minister for Public Health Melanie Johnson admitted that there is no evidence of such a trend. Furthermore, the Home Office has previously stated that migrants do not represent a burden to the NHS with “deliberate” health tourism present only at very low levels²⁷².

ECONOMICS

5. Minimal savings will result from the denial of primary care without advance payment. It is crucial that a full health and equality impact assessment is conducted prior to the introduction of any further barriers to accessing NHS treatment for vulnerable migrants.

6. Newham PCT is the only Trust to have carried out a Health Impact Assessment on the identification and charging of overseas visitors in primary care. The study found that “The cost benefits of implementing a suitable system must also be viewed in light of a study showing that, in a borough with a high migrant population, it was estimated that approximately 100 GP visits across the borough might be chargeable equating to perhaps £3,000 of income [per month].”²⁷³

7. Early intervention in a primary care setting is extremely cost-effective. The cost of a GP consultation for chronic asthma is £20, compared with £1488 for an Accident and Emergency consultation, intubation and an overnight stay in ITU for an acute severe exacerbation of asthma²⁷⁴. Currently, 86% of all healthcare needs are met cheaply in primary care²⁷⁵.

8. Denying access to primary care will result in increased numbers of patients, with routine and chronic conditions, presenting acutely to emergency departments, requiring treatment deemed “immediate and necessary”²⁷⁶. It is unclear how Emergency Departments are expected to cope with this influx of patients or the additional financial burden that will be placed on their services.

9. Should the proposals be implemented, official guidance on discerning whom to charge will need to be provided. Additional staff will be required to shoulder this new administrative burden at additional cost to the NHS. The UK hosts a multi-racial society, and many patients will object to having their immigration status challenged on the basis of a “foreign-sounding” name. This has already occurred in some instances in secondary care²⁷⁷.

10. Doctors should not be required to use denial of healthcare as a lever for immigration policy. To do so would be in breach of the professional and ethical duties of medical professionals, which include making patient care paramount and protecting public health²⁷⁸. The NHS was founded on fundamental principles that health care should be freely available to all irrespective of an individual’s background.

11. Previous resolutions at their annual meetings of the British Medical Association have deplored “the planned withdrawal of rights to medical care from asylum seekers whose applications have been refused” [2004] and later asserted that it is “not appropriate for medical staff to act as proxy immigration officers in seeking to determine the immigration status of people presenting for care and treatment.” [2005].

²⁷¹ Medact. Proposals to exclude overseas visitors from eligibility to free NHS Primary Medical Services: impact on vulnerable migrant groups. London, 2005. Available at: <http://www.medact.org/content/refugees/Briefing%20V1%20agreed.pdf>

²⁷² Home Office. Enforcing the rules: a strategy to ensure and enforce compliance with our immigration rules. London: Home Office, 2007.

²⁷³ Hargreaves S, Friedland JS, Holmes A. The identification and charging of Overseas Visitors at the NHS Services in Newham: a Consultation. London, 2006. Available at: <http://www.newhampct.nhs.uk/docs/publications/IHUEntitlementReport06.pdf>

²⁷⁴ Health Care Commission. State of Healthcare. London, 2006.

²⁷⁵ Pereira Gray D. Dozen Facts about General Practice. London. Revised 2005.

²⁷⁶ Department of Health Statutory Instrument 2004 No. 614 (S1614). Available at: <http://www.opsi.gov.uk/si/si2004/20040614.htm>

²⁷⁷ Yates T, Crane R, Burnett A. Rights and the reality of healthcare charging in the United Kingdom. *Medicine, Conflict and Survival* 23(4): 297–304.

²⁷⁸ http://www.gmc-uk.org/guidance/good_medical_practice/duties_of_a_doctor.asp
HPA, *Migrant Health. Infectious diseases in non-UK born populations in England, Wales and Northern Ireland. A baseline report—2006.* Available at: http://www.hpa.org.uk/publications/2006/migrant_health/default.htm

²⁷⁹ Joint Committee on Human Rights, *The treatment of asylum seekers: tenth report of session 2006–7*, 2007.

Whether the Government is likely to meet its Public Service Agreement targets in respect of health inequalities.

Life Expectancy and Infant Mortality

12. The current regulations applicable to secondary care state that all antenatal, birth and postnatal care is to be considered immediately necessary, and should be provided irrespective of ability to pay. This not mean that maternity care is free but instead that women should not be denied care if they cannot pay the charges. However, the current arrangement for levying charges has resulted in instances of vulnerable women being denied antenatal care²⁸⁰.

13. In 2006, 86% of women having their first child made first contact with their GP, and this figure was higher amongst black and minority ethnic women. While policies promote direct access to midwives, the most common pathway into maternity care is through a GP appointment²⁸¹. Excluding vulnerable migrants from free GP services is likely to prevent or delay access to maternity care. Late booking for maternity care is a major risk factor for maternal death²⁸² and is linked to infant mortality²⁸³.

14. Vulnerable migrants are at particular risk of maternal deaths and infant mortality. Social disadvantage, living in poor communities and minority ethnic status are associated with significantly higher maternal mortality rates²⁸⁴. The CEMACH Report "Saving Mothers' Lives" found that "Black African women, including asylum seekers and newly arrived refugees have a mortality rate nearly six times higher than White women. To a lesser extent, Black Caribbean and Middle Eastern women also had a significantly higher mortality rate²⁸⁵." Infant mortality is closely associated with socio-economic status and babies born to the most socially disadvantaged group (NS-SEC Other) have infant mortality rates almost twice that of the population as a whole²⁸⁶.

15. The CEMACH Report recommends that "All pregnant mothers from countries where women may experience poorer overall general health, and who have not previously had a full medical examination in the United Kingdom, should have a medical history taken and clinical assessment made of their overall health, including a cardio-vascular examination at booking, or as soon as possible thereafter. An appropriately trained doctor, who could be their usual GP, should perform this. Women from counties where genital mutilation, or cutting, is prevalent should be sensitively asked about this during their pregnancy and management plans for delivery agreed during the antenatal period."

16. The above evidence suggests that the Government is unlikely to meet its PSA Target in respect of health inequalities if the proposals to charge vulnerable migrants for primary care services are introduced. Vulnerable migrants are more likely to be living in poor communities, such as those Local Authorities included in the Spearhead Group, which contains 44% of the Black and Ethnic Minority population of England. Life expectancy is increasing for both men and women nationally, including the Spearhead areas. However, the increase in the Spearhead areas is slower, and so the gap continues to widen. The gap is widening more for men than women²⁸⁷. The negative impact the proposals will have on access to maternity services is likely to further increase the maternal mortality of vulnerable migrants, many of whom will live in Spearhead areas, serving to further exacerbate this gap in life expectancy.

Mental Health

17. Objective 1 of the Spending Review 2004 Public Service Agreement is to substantially reduce mortality rates by 2010, including those from suicide and undetermined injury by at least 20%²⁸⁸. Migrants from refugee generating countries that face war, upheaval and / or economic decline, who include refugees, migrant workers, and undocumented migrants, are known to be a particularly vulnerable population facing many barriers to accessing appropriate primary care²⁸⁹. These arise from communication problems, social exclusion, cultural differences, poverty and poor accommodation²⁹⁰.

²⁸⁰ Joint Committee on Human Rights, *The treatment of asylum seekers: tenth report of session 2006–7*, 2007.

²⁸¹ Redshaw M, Rowe R *et al*, Recorded delivery: national survey of women's experience of maternity care 2006, National Perinatal Epidemiology Unit 2007. Available at: http://www.npeu.ox.ac.uk/maternitysveys/maternitysveys_downloads/maternity_survey_report.pdf

²⁸² Royal College of Obstetricians and Gynaecologists, Confidential enquiry into Maternal and Child Health, *Why Mothers Die 2000–2002*. The sixth report London, 2004. Available at: <http://www.cemach.org.uk/Publications.aspx>

²⁸³ Department of Health, Review of the health inequalities infant mortality PSA target, 2007. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_065544

²⁸⁴ Department of Health, Review of the health inequalities infant mortality PSA target, 2007. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_065544

²⁸⁵ Confidential Enquiry into Maternal and Child Health. *Saving Mothers' Lives: reviewing maternal deaths to make motherhood safer—2003–2005. Executive Summary and Key Recommendations*, 2007.

[http://www.cemach.org.uk/getattachment/ad9cb3fc-fa69-4374-b104-1946b855378f/Why-Mothers-Die-2000-2002-\(1\).aspx](http://www.cemach.org.uk/getattachment/ad9cb3fc-fa69-4374-b104-1946b855378f/Why-Mothers-Die-2000-2002-(1).aspx)

²⁸⁶ Department of Health, Review of the health inequalities infant mortality PSA target, 2007. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_065544

²⁸⁷ Tackling Health Inequalities: 2003–05 data update for the National 2010 PSA Target, 2006. Available at: http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Healthinequalities/Healthinequalitiesguidancepublications/DH_064183

²⁸⁸ http://www.dh.gov.uk/en/Aboutus/HowDHworks/Servicestandardsandcommitments/DHPublicServiceAgreement/DH_4106188

²⁸⁹ Hargreaves, S., Friedland, J.S., Gothard, P., Saxena, S., Millington, H., Eliahoo, J., Le Feuvre, P. and Holmes, A. (2006) Impact on and use of health services by international migrants: questionnaire survey of inner city London A&E attenders. *BMC health services research*. 6 (153): 1–7.

²⁹⁰ Burnett, A and Peel, M. (2001) Health needs of asylum seekers and refugees. *BMJ*. 322:544–7.

18. Furthermore, asylum seekers whose asylum claim has failed or who do not have support from refugee organisations or family have also been noted to experience hardships accessing primary care services²⁹¹. This has huge implications for this population's welfare. For example, many refugees and asylum seekers have been victims of rape, torture and numerous violent attacks or have witnessed these atrocities occur to family members or friends. Consequently, numerous mental health issues such as anxiety, depression, post-traumatic stress disorder and feelings of guilt and shame are more prevalent in this population and increased suicide rates²⁹².

19. GPs provide an essential gateway service to recognising these issues and referring this population to various multidisciplinary mental health services depending on their needs. Consequently, the proposed government plan to exclude certain migrant population groups from accessing free primary healthcare threatens to widen the health and life expectancy gap between the UK migrant population and the rest of the UK and may enhance suicide rates within this population.

The distribution and quality of GP services and their influence on health inequalities, including how the Quality and Outcomes Framework and Practice-based Commissioning might be used to improve the quality and distribution of GP services to reduce health inequalities;

20. The financial incentive provided by QOF may affect the internal motivation of doctors²⁹³. Full points are available for the majority of QOF targets with less than 100% coverage, and inevitably those who do not attend and are most difficult to follow up and achieve target with are the most vulnerable. Where only 90% coverage is needed, GPs are less inclined to follow up the most difficult to reach 10%, and doctors may be less likely to chase up and give adequate care to the most vulnerable patients.

21. The focus of QOF on individual diseases does not encourage practitioners to use a patient-centred approach. This is particularly harmful to those with multiple co-morbidities or mental health problems, both of which are more prevalent in lower socioeconomic groups. QOF should focus more on outcome measures, such as complications of diabetes rather than blood pressure, and a patient-centred approach should be encouraged. There is evidence to show that current outcome measures do not accurately reflect the effectiveness of clinical care²⁹⁴.

The effectiveness of public health services at reducing inequalities by targeting key causes such as smoking and obesity, including whether some public health interventions may lead to increases in health inequalities; and which interventions are most cost-effective;

22. Public health interventions in schools have great potential to reach individuals at a young age and regardless of social status. The EPODE study²⁹⁵ in France shows good results for community interventions aimed at decreasing obesity in childhood. This is an example that the UK Department of Health should be following.

The success of NHS organisations at co-ordinating activities with other organisations, for example local authorities, education and housing providers, to tackle inequalities; and what incentives can be provided to ensure these organisations improve care

Reduce Economic Inequality to reduce Health Inequality

23. Economic inequality is the strongest predictor of health inequality, and must thus be reduced. Economic inequality can be reduced through more redistributive taxing systems and more equal pay systems, with a higher minimum wage and higher pay for those employed by the state with the lowest wages. [Providing government loans to enable employees to buy out the companies that they work for is another means to reduce inequality, as where employees own companies, pay differentials between highest and lowest paid workers would tend to decrease. Employee buyouts could also be incentivised by offering tax breaks to companies that are owned by their employees²⁹⁶.]

²⁹¹ Burnett, A and Peel, M. (2001) Health needs of asylum seekers and refugees. BMJ. 322:544–7.

²⁹² Feldman, R. (2006) Primary Health care for refugees and asylum seekers: A review of the literature and a framework for services. Public Health. 120: 809–816.

McColl, H. And Johnson, S. (2006) Characteristics and needs of asylum seekers and refugees in contact with London community mental health teams: A descriptive investigation. Social Psychiatry and Psychiatric Epidemiology. 41:789–795.

Ward, K and Palmer, D. Mapping the provision of mental health services for asylum seekers and refugees in London: a report [internet]. Information centre about asylum and refugees in the UK (ICAR). Kings College London. London, 2005.

²⁹³ McDonald R, Harrison S, Checkland K, Campbell SM, Roland M, Impact of financial incentives on clinical autonomy and internal motivation in primary care: ethnographic study. BMJ. June 30, 2007; 334(7608): 1357–1357.

²⁹⁴ Downing A, Rudge G, Cheng Y, Tu Y, Keen J, Gilthorpe MS, Do the UK government's new Quality and Outcomes Framework (QOF) scores adequately measure primary care performance? A cross-sectional survey of routine healthcare data. BMC Health Services Research 2007, 7:166.

²⁹⁵ www.epode.fr

²⁹⁶ Wilkinson R, The Impact of Inequality: How to make sick societies healthier. London: Routledge, 2005.

24. Poorer people are less able to afford their own vehicle and are therefore more dependent on public transport. In order to reduce inequality, the Department for Transport must ensure that services are made cheaper, more joined-up and more accessible. A health impact assessment in Edinburgh finds that:

“greater spend on public transport and supporting sustainable modes of transport was beneficial to health, and offered scope to reduce inequalities.”²⁹⁷

January 2008

Memorandum by Diabetes UK (HI 40)

THE CONTRIBUTION OF THE NHS TO REDUCING HEALTH INEQUALITIES

INTRODUCTION

1. Diabetes UK welcomes the Health Select Committee's inquiry into the contribution of the NHS to reducing health inequalities and the opportunity to have some input.

2. Our submission focuses on Diabetes UK knowledge and experience in four areas:

- The extent to which the NHS can contribute to reducing health inequalities,
- The quality of GP services and how the Quality and Outcomes Framework and Practice-based Commissioning might be used to improve the quality of GP services to reduce health inequalities.
- Effectiveness of public health services at reducing inequalities by targeting key causes such as smoking and obesity.
- The effectiveness of the Department of Health in co-ordinating policy with other government departments, in order to meet its Public Service Agreement targets for reducing inequalities; and whether the Government is likely to meet its Public Service Agreement targets in respect of health inequalities.

ABOUT DIABETES UK

3. Diabetes UK is one of Europe's largest patient organizations. We are a major funder of research in both Type 1 and Type 2 diabetes with plans to spend £7.38 million in 2008. Our mission is to improve the lives of people with diabetes and to work towards a future without diabetes through, care, research and campaigning. With a membership of over 175,000 and over 6000 health care professionals, Diabetes UK is an active and representative voice of people living with diabetes in the UK.

THE EXTENT TO WHICH THE NHS CAN CONTRIBUTE TO REDUCING HEALTH INEQUALITIES

4. While poverty, unemployment and bad housing etc. are a major cause of the differences in health status and life expectancy, lack of access to good quality care is a critical factor in the persistence of health inequality. It is still the case that those in the greatest need for healthcare are still least likely to get it, as responses to this challenge remain consistently piece-meal and short sighted.

5. The most striking inequality is the almost universal tendency for people in lower socioeconomic groups to die younger and to suffer more illness during their lifetime compared to those in higher socioeconomic groups. These socioeconomic disparities cannot readily be dismissed as biological facts or historical inevitabilities, which mean most health inequalities point to a failure of national and local policy, planning and delivery of services including health.

6. Diabetes is a long term condition which is particularly illustrative of failures in provision which could help prevent Type 2 diabetes as well prevent, delay or reduce the seriousness of complications of Type 1 and Type 2 diabetes. The numbers diagnosed with diabetes are expected to reach over 3 million by 2010; around half of these will be people from disadvantaged communities. In fact the most deprived in the UK are 2.5 times more likely to have diabetes (in the North East of England the prevalence of diabetes is 45% higher in women and 28% higher in men than the national average). Also alarming is that complications of diabetes such as heart disease, stroke and kidney damage are three and a half times higher among lower socioeconomic groups. And those who are least well educated are more likely to have retinopathy, (diabetes is the leading cause of blindness in the working age population), heart disease and poor diabetes control.²⁹⁸

²⁹⁷ Gorman D, Douglas MJ, Conway L, Noble P, Hanlon P, Transport policy and health inequalities: a health impact assessment of Edinburgh's transport policy. *Public Health*, 1 January 2003, 117, 1: 15–24.

²⁹⁸ All Parliamentary Group for Diabetes (2006), *Diabetes and the disadvantaged: reducing health inequalities in the UK*.

7. Alongside this evidence, many studies of specific NHS services, yield strong evidence that lower socio-economic groups access health services less in relation to need than higher ones.²⁹⁹ Research shows that there are two distinct disadvantages that lower socio-economic groups experience: problems with making initial contact with the health service, and problems once contact has been established. Compared to higher socioeconomic groups, when ill, those in lower groups either tend to not go to the doctor at all, or present at a later stage with their condition, they often go to accident and emergency departments instead of GP surgeries; and when well, they tend not to access prevention services. When they do establish contact with services, lower socioeconomic groups have lower rates of referral to secondary and tertiary care, lower rates of intervention relative to need, and lower and irregular attendance at chronic disease management clinics, this includes diabetic clinics and diabetes reviews.³⁰⁰

8. Tackling this unfairness means changing the attitudes of commissioners, providers and health professionals to be more locally engaged and creative in the design and delivery of services. It also means building the capacity of local people to access and use health services, and their own ability to manage their health and well-being. Given the evidence that people in deprived areas are often reluctant to visit their GPs, it is incumbent on PCTs to identify these groups understand why they do not access traditional care and tailor services accordingly. This could mean using community nurses and pharmacists, offering services over the phone or in shopping centres and working with voluntary organisations as well as those in social care.

9. However findings from the Healthcare Commission published in Dec 2007 reveal that many PCTs do not fully understand the health needs of their local people, making it difficult for them to commission responsive services.³⁰¹ This means important provisions for diabetes prevention and management of the condition are not being made. Eighty five per cent of PCTs did not have arrangements for providing education programmes for patients with diabetes in their area, and 2,000 GP practices did not fulfill their PCT's plans to establish registers for people at risk of coronary heart disease (a complication of diabetes as well as a risk factor). In addition, 2.3 million people did not have their BMI index recorded as planned, with GPs not recording the data, which provides vital statistics on levels of obesity, another risk factor for diabetes.³⁰²

10. Diabetes education programmes are vital because 95 per cent of diabetes care is via self management, yet previous work by the Healthcare Commission shows that only 11 per cent of patients have received an education programme. In addition, four out of five people with Type 2 diabetes are overweight, so it's critical that BMI measurements are recorded. It is unacceptable that around a quarter of GP practices are failing to establish registers for those at risk of coronary heart disease which affects 80 per cent of people with diabetes.

11. These problems are magnified in socially deprived areas where there is a higher incidence rate of diabetes, and the most vulnerable are even less likely to get the diabetes support they need- with 18 per cent fewer GPs than in the least deprived areas.

12. In view of this, Diabetes UK greatly welcomes the Prime Minister's announcement that there will be monitoring/screening for heart disease, strokes, diabetes and kidney disease—conditions which affect the lives of 6.2 million people, cause 200,000 deaths each year and account for a fifth of all hospital admissions and also stronger sanctions against poor performance.

13. Diabetes UK has been calling for many years for programmes for the early identification of people with Type 2 diabetes early. People can remain undiagnosed with the condition for up to 12 years, so screening is vital to ensure appropriate diabetes care and treatment. There are upto 750,000 people in the UK who have Type 2 diabetes but are unaware.. Targeted screening programmes will go a long way towards reducing the devastating and costly diabetes-related complications of coronary heart disease, kidney disease, blindness, stroke and amputations."

14. Diabetes UK is aware of some pockets of good practice around the country. Slough PCT identified a growing diabetes problem in the community and developed the "Action Diabetes" project. The project identified a significant number of people with undiagnosed diabetes, raised the profile of the condition and strengthened links with Asian communities. Since the project launch in Oct. 2004, diabetes referrals have increased by 164%.

THE QUALITY OF GP SERVICES AND HOW THE QUALITY AND OUTCOMES FRAMEWORK AND PRACTICE-BASED COMMISSIONING MIGHT BE USED TO IMPROVE THE QUALITY OF GP SERVICES TO REDUCE HEALTH INEQUALITIES.

15. Implementation of the Quality and Outcomes Framework (QOF) has resulted in a very welcome increase in the monitoring of patients, especially those with Type 2 diabetes. At the same time though introduction of the QOF has managed to undermine real quality patient-centred care, and done little if anything to address inequalities.

²⁹⁹ Dixon A, Le Grand J, Henderson J, Murray Richard, Poteliakhoff E, (2003) *Is the NHS equitable?* LSE Health and Social Care Discussion Paper 11.

³⁰⁰ *Ibid.*

³⁰¹ *Healthcare Commission (2007)*, State of Healthcare report.

³⁰² *Ibid.*

16. The Quality and Outcomes Framework (QOF) is essentially a payment mechanism for clinical activities and processes. Thus it concentrates on tasks that are easily measurable giving the QOF a narrow remit, largely ignoring outcomes and patient focused elements of quality care such as information, education and empowerment which are deemed important by patients and the National Service Frameworks. The QOF is fundamentally a medical model of service delivery which is not built to deliver individual and holistic care. Clearly then there is a need for balance between a medical model and a patient-centred model which encourages patient engagement and self-care, and ultimately better health outcomes for the patient.

17. QOF points allocated to indicators should prioritise outcome measures, rather than process measures. The number of points awarded for “process targets” should be reduced and the number of points awarded for outcome targets should increase proportionally. Since nearly all GPs are reporting over 75% achievement of process measures, the points should be reallocated to outcome measures that are more challenging to achieve. For instance a higher proportion of people with diabetes should be achieving tighter management targets for HbA1c, blood pressure and cholesterol. Furthermore, thresholds for all diabetes indicators should be reviewed and increased to encourage those practices achieving the lower range of the threshold to focus on delivering better services to people with diabetes.

18. The submission of evidence within the QOF review process is very clinically focused with a bias towards Randomised Controlled Trials. While the results of such trials are of significant value, the process does not allow for qualitative evidence to feed into the process. Patient feedback and qualitative evidence have a role to play in influencing the development and quality of indicators that are evidence based and patient centred.

19. Diabetes UK has also received concerns from people with diabetes and professionals working within diabetes care about exception coding. We are concerned about the delivery of care for people with diabetes who are exception coded. Mechanisms need to be in place to ensure that those who are excluded, for instance those within residential homes, have access to the care they need.

20. Presently the QOF does not encourage practices to support vulnerable patients, eg housebound patients, or those in residential care. Analysis shows that some practitioners are using exclusions to ensure that targets are achieved. Although exception reporting is not extensive, it has been identified is a strong predictor of achievement—with 1 per cent of practices excluding more than 15 per cent of patients. Further analysis of the impact of exception reporting on health outcomes and inequalities is required. The level, range and reasons why people are exception reported needs to be examined to identify the impact on patient outcomes. Diabetes UK is currently examining the varying levels of exception coding.

21. The QOF also does not encourage the proactive driving of health improvements. In the case of diabetes there is no incentive for a practice to develop register of those patients at risk of diabetes. An “at risk register” would target early on those people at risk of diabetes, thereby reducing their risk of further serious complications.

22. Another concern we currently have is the commissioning and co-ordination of diabetes care. Overtime most diabetes patients move between primary and secondary care according to their needs and the nature of their complications. Presently though “downsizing” of some specialist units by local primary care trusts, in line with the government’s desire to transfer most, if not all of chronic disease management from secondary to primary care has begun to see a decline in recruitment into the specialty and many unfilled consultant posts. If as a result specialist services are lost or increasingly fragmented then it will be difficult to recreate them. Without competent professionals general practitioners and primary care will be left unsupported and access to specialists for patients with complicated diabetes related problems will be reduced, undoubtedly hitting the most disadvantaged groups the hardest. In theory, practice based commissioning could help to structure and coordinate services to deliver responsive patient-centred care, ensuring that only services that can be safely transferred to primary care do so, and the competence of staff providing these services is assured. However we presently have no evidence to support this theory, and we do have concerns about the capability of GP practices to undertake complex commissioning, as we do of current PCT commissioning.

23. Finally then mechanisms such as QOF, Practice Based Commissioning and Payment by Results need to work together, to produce an integrated system for monitoring and rewarding quality across the entire network of care provision. This is essential for a creating a system of care that is coordinated and designed around the needs of patients.

EFFECTIVENESS OF PUBLIC HEALTH SERVICES AT REDUCING INEQUALITIES BY TARGETING KEY CAUSES SUCH AS SMOKING AND OBESITY.

24. People in lower socio economic groups are 50% more likely to smoke than those on the higher socio-economic groups. Obesity is nearly 50% higher amongst women in lower socio economic groups. Deprivation is strongly associated with higher levels of obesity, physical inactivity and unhealthy diet, smoking and poor blood pressure control. All these factors put people at high risk of diabetes as well as serious risk of crippling complications amongst those already diagnosed with diabetes.³⁰³ Therefore targeting key causes of ill-health such as smoking and obesity is a long overdue and a very much welcome move.

³⁰³ All Parliamentary Group for Diabetes (2006), *Diabetes and the disadvantaged: reducing health inequalities in the UK*.

25. It is estimated that diabetes represents 9% of hospital costs. Diabetes increases by five the chance of a person needing hospital admission. Drugs used in diabetes are the second biggest cost on the national drugs bill, between 2004 and 2005 costs of drugs used in diabetes grew by 11% and items prescribed by 10%. Diabetes deaths already number over 30,000 in the UK and this figure is set to increase by 25 per cent by 2015. We know that adopting a healthy diet and increasing physical activity could prevent 80 per cent of Type 2 diabetes.

26. Furthermore work by the Strategy Unit reveals that in 2002 the cost of people being obese and overweight in England was estimated at nearly £7 billion including direct treatment costs, state benefits and loss of earnings. Obesity rates have trebled in the past 20 years and it is expected that 60 per cent of Britons will be obese by 2050. The Strategy Unit report says boosting fruit and vegetable consumption to the recommended five pieces per day could cut 42,000 premature deaths each year.³⁰⁴

27. The health and well-being of the next generation is a concern for all of society. Evidence of increase in childhood obesity and early onset of Type 2 diabetes demands tighter controls on the marketing of unhealthy foods to children, alongside building the capacity of children to understand food and health. Therefore Diabetes UK wants to see:

- The introduction of a 9pm watershed for junk food television adverts
- The introduction of statutory controls to reduce children's exposure to other junk food marketing, particularly online and via mobile phones
- Making food skills, including cookery a compulsory part of the national curriculum, so that every child leaves school knowing how to make nutritious meals
- Support the Food Standards Agency's traffic light labelling model by accelerating the process of making it a legal requirement (which means working with other EU countries)

28. With regard to smoking Diabetes UK welcomes the introduction of the new law on 1st July 2007 making virtually all enclosed public places and workplaces in England smokefree. A smokefree England ensures a healthier environment, so everyone can socialise, relax, travel, shop and work free from secondhand smoke.

29. Effective tobacco control measures are required to reduce the damage caused to people who smoke, but also children who are exposed to second hand smoke. The impact of smoking on the development and progression of micro vascular complications of diabetes is profound. In men who smoke the risk of developing diabetes alone is doubled. In women who smoke 25 cigarettes or more a day the risk of developing diabetes is increased by 40 per cent.³⁰⁵

30. Smokers with diabetes are at greater risk of developing the devastating complications of diabetes. They are more likely to die of cardiovascular disease than their non-smoking counterparts. In combination with diabetes smoking greatly enhances the likelihood of premature mortality.

THE EFFECTIVENESS OF THE DEPARTMENT OF HEALTH IN CO-COORDINATING POLICY WITH OTHER GOVERNMENT DEPARTMENTS, IN ORDER TO MEET ITS PUBLIC SERVICE AGREEMENT TARGETS FOR REDUCING INEQUALITIES; AND WHETHER THE GOVERNMENT IS LIKELY TO MEET ITS PUBLIC SERVICE AGREEMENT TARGETS IN RESPECT OF HEALTH INEQUALITIES.

31. The Department of Health has made great strides in seeking to co-ordinate policy with many other government departments in relation to health and health inequalities. It is also encouraging to see explicit focus on health inequalities—tackling smoking prevalence, supporting early identification of disease etc. However it is debatable whether Government will meet all of its targets in relation to health inequalities. In view of the scale of the challenge of deep rooted inequalities it is perhaps more important that the government identifies and seeks to apply the appropriate solutions rather than chase artificial targets. Taking the example of childhood obesity, it is refreshing to see that the Government is developing a comprehensive cross-departmental strategy on obesity, building on the evidence in the Foresight report.

32. Regard to the PSA target on childhood obesity we have noted that the original target has been altered. The target set in 2004 sought to halt the year-on-year rise in obesity among children under the age of 11 by 2010. In the 2007 Comprehensive Spending Review the target seeks to reduce the rate of increase in obesity among children under 11 as a first step towards a long-term national ambition by 2020 to reduce the proportion of overweight and obese children to 2000 levels in the context of tackling obesity across the population. It could be argued that moving the target to 2020 is an admission of defeat; on the other hand it could also be interpreted as a more realistic timeframe for meeting the challenge. As such while we cannot be 100 per cent confident that current or future Government will meet the target, we are confident that the current Government is committed to trying to do so. The evidence for this so far is:

- the commitment to spend £225 million over the next three years to:
- offer every local authority capital funding that would allow up to 3,500 playgrounds nationally to be rebuilt or renewed and made accessible to children with disabilities;

³⁰⁴ *The Strategy Unit (2008) Food: an analysis of the issues*, Cabinet Office.

³⁰⁵ International Diabetes Federation Bulletin, vol 43, No. 4/98.

- create 30 new adventure playgrounds for 8- to 13-year-olds in disadvantaged areas, supervised by trained staff;
- To improve children's health the Government will:
- publish a Child Health Strategy in spring 2008, produced jointly between the Department for Children, Schools and Families and the Department of Health; and publish a play strategy by summer 2008
- The focus on obesity will be enhanced by the creation of a cross-Governmental Ministerial Group. A new joint Obesity Unit, supported by the Department for Children, Schools and Families and the Department of Health, is being established to tackle obesity.

January 2008

Memorandum by Professor Jill Belch and others (HI 41)

HEALTH INEQUALITIES

1. We write with reference to the Health Select Committee which has launched an inquiry into how the NHS can reduce health inequalities. We wish to address one area of focus—"how the Quality and Outcomes Framework and Practice based Commissioning might be used to improve the quality and distribution of GP services to reduce health inequalities". We submit this evidence as members of the medical profession who regularly deal with patients afflicted by Peripheral arterial disease (PAD).

2. PAD is a narrowing of the arteries that supplies blood to the legs. The narrowed arteries cannot carry enough blood, which may cause patients to experience pain in the legs when walking. This is called intermittent claudication (IC). It not only affects a person's ability to walk -it is essentially a manifestation of widespread hardening of the arteries (atherosclerosis) and these patients are at huge risk of events elsewhere eg Stroke and Heart Attack.

3. Stroke, Heart attack and PAD are all the same disorder ie atherosclerosis. Our contention is that patients with PAD are being treated unequally compared to these other vascular disease groups. This is true for both the management of risk of future heart attacks and strokes, and in the treatment of PAD symptoms. PAD is highly prevalent and although associated with a significant risk of future heart attack and stroke it remains under diagnosed and under treated in the UK. It is more common in those who smoke and those who are elderly, and in those who are socially disadvantaged. Thus improved treatment of PAD in the population as a whole will help to reduce inequalities. It is a common disorder, affecting approximately 1 in 8 patients over the age of 55 in the UK.

4. To reiterate—a direct analogy can be drawn with our understanding of diabetes where it is not the presenting disease (diabetes) that is accountable for death but the associated cardiovascular risk factors. Unfortunately, patients with PAD often do not receive proper care until the associated devastating heart or brain attack occurs. Aggressive risk factor management, (blood fat (cholesterol), high blood pressure, diabetes, sticky blood cells (platelets)) and smoking cessation counselling in patients with PAD will prevent many premature deaths and much unnecessary suffering. PAD is a major marker for future events (more than chronic stable angina!). As a result, 60% of PAD patients die from heart attack and 12% from stroke. Furthermore, patients with symptomatic PAD have significantly reduced mobility and poor quality of life, equating to some cancers. Symptomatic treatment is infrequently given to these patients. PAD needs to be included in the GMS contract and other health initiatives, so that doctors are informed and motivated to provide appropriate care for these patients.

5. Proven preventative treatments are readily available. Many large scale international studies have provided clear evidence that managing these risk factors prevents heart attack, stroke and death in these PAD patients. In particular, the Heart Protection Study addresses the value of cholesterol control, and the CAPRIE study and others the value of anti-platelet agents.

6. If the GMS contract is to achieve its aim of improving healthcare and reducing death from Cardiovascular disease, it cannot continue to ignore a substantial subgroup of patients with such a disorder ie patients with PAD. The case that PAD should be treated as an equivalent to coronary disease is beyond doubt and we are convinced that the addition of PAD to the GMS contract should be brought about as speedily as possible. Our position is that PAD needs to have an appropriate allocation of points from the 152 points currently given to cardiovascular conditions. A simple mechanism would be to change coronary heart disease (CHD) to cardiovascular disease (CVD) and thus PAD Patients would be included in the

current assessment programme! We would urge all those involved in assessing inequalities in health care to actively support this alternative as a proposed, and probably successful, method of reducing Cardiovascular mortality in line with Government targets.

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Professor Gerry Stansby, MChir, FRCS

(Professor of Vascular Surgery, University of Newcastle, Consultant Vascular Surgeon Northern Vascular Unit, Co-Chair TARGET-PAD group and Council Member of The Vascular Society of Great Britain and Ireland).

Mr Michael Gough, MB, ChB, ChM, FRCS.

(Consultant Vascular Surgeon, Leeds Vascular Institute and President of the Vascular Society of Great Britain and Ireland).

Mr Jonathan Earnshaw, MB, BS, DM, FRCS.

(Consultant Vascular Surgeon, Gloucestershire Royal Hospital, and Secretary of the Vascular Society of Great Britain and Ireland).

Professor Cliff Shearman, BSc, MB, BS, MS, FRCS.

(Professor of Vascular Surgery, University of Southampton, Consultant Vascular Surgeon, Southampton General Hospital, Council Member of the Vascular Society of Great Britain and Ireland, member of the TARGET-PAD group).

Professor Gerry Fowkes, MBChB, PhD, FRCPE, FFPH

(Professor of Epidemiology, Public Health Sciences, University of Edinburgh and Chair of Scottish Intercollegiate Guidelines Network (SIGN) Guidelines Group on PAD).

January 2008

Memorandum by the Children's Heart Federation (HI 42)

HEALTH INEQUALITIES

1. INTRODUCTION

The Children's Heart Federation is a national charity and the umbrella body for voluntary organisations working to meet the needs of children and young people with congenital and acquired heart conditions and their families. We provide information and support, medical equipment and grants, and campaign to improve the clinical and social care of children with heart conditions.

The Children's Heart Federation believes that there are a number of ways in which the NHS can help to achieve a reduction in health inequalities for children and adults with congenital heart conditions. We have identified the following objectives as being central to improving health inequalities for children and adults with congenital heart condition:

- All children with heart conditions should receive the same high quality of treatment
- All adults with congenital heart disease should receive a high standard of ongoing care and treatment.
- Pregnancy should be seen as a key point of intervention in terms of creating a healthy environment for the foetus and hence reducing the risk of birth defects.
- All children with heart conditions and their families should get the right services and support, should be fully included in society, and have access to an education system that meets the needs of each child.

2. FACTUAL INFORMATION

- One in every 145 children is born with a heart condition.
- Congenital heart conditions are the most common birth defect in the UK, and a leading cause of birth-defect related deaths world-wide.
- There are currently about 135,000 young people living with a heart condition.
- Research suggests drinking alcohol and taking drugs during pregnancy could increase the risk of congenital heart disease.

3. RECOMMENDATIONS FOR ACTION

In view of the above, we would urge the Committee to consider the following recommendations in their inquiry:

- To reorganise paediatric cardiac services in line with recommendations from the Report of the Paediatric Congenital Cardiac Services Review Group, published in December 2003 following the Bristol Inquiry.

In order for centres to provide a high quality of treatment to patients, their teams need to be performing a large quantity of procedures each year. The rationale is that a high number of procedures will ensure that surgeons maintain their competencies. The Children's Heart Federation is particularly concerned that there are currently some paediatric cardiac centres with only a single consultant surgeon, bringing into question the quality and safety of treatment for patients. We believe that the current arrangement of paediatric cardiac services needs to be reorganised to centralise expertise and resources such that every centre is capable of providing a high quality and safe treatment to all children with heart conditions.

- Young people and adults with congenital heart conditions should receive uninterrupted and coordinated care covering the transition from children's to adults services, as well as between specialist and local centres, primary care, obstetric care and other special needs.
- Lifestyle choices that prospective mothers can make may reduce the risk of giving birth to a baby with heart defects. We therefore see the work of public health services targeting lifestyle choices, such as smoking, as being a key contributor in the quest to reduce health inequalities.
- A specific duty on local authorities and education providers to assess and provide for the needs of children with heart conditions and their families. The health difficulties of children with heart conditions are not always obvious. As a result, any learning, physical, and emotional difficulties may be easily overlooked or misunderstood. This can make it even more difficult for parents to get the help and support that their child needs.

January 2008

Memorandum by Philip Morris Limited (HI 43)

THE CONTRIBUTION OF THE NHS TO REDUCING HEALTH INEQUALITIES

1. Philip Morris Limited ("PML")³⁰⁶ is pleased to provide to the Health Committee (the "Committee") its comments on the Inquiry into the contribution of the NHS to reducing health inequalities.

2. We want to work with governments, public health authorities and parliamentarians on strong and effective regulation of our industry and our products. We welcome this opportunity to present our views to this Inquiry.

3. In particular, we would like to comment on two aspects outlined in the Inquiry's Terms of Reference:

- "The effectiveness of public health services at reducing inequalities by targeting key causes such as smoking and obesity, including whether some public health interventions may lead to increases in health inequalities; and which interventions are most cost-effective"
- "The effectiveness of the Department of Health in co-ordinating policy with other government departments, in order to meet its Public Service Agreement targets for reducing inequalities"

INTRODUCTION

4. We fully recognise that smoking is addictive and causes serious and fatal diseases. There is no such thing as a "safe" cigarette. Given their serious health effects, we fully support comprehensive tobacco regulation governing the manufacture, marketing, sale and use of tobacco products based on the principle of harm reduction.

5. As the then Vice President of Corporate Affairs for Philip Morris Europe, Mr. David Davies, explained to the Committee in January 2000³⁰⁷ we support a single, consistent public health message on the health effects of smoking. This includes for example our support of legislation that requires cigarette manufacturers to place health warnings on packages, and our belief that governments and public health officials should determine the content of the warning messages³⁰⁸.

³⁰⁶ Philip Morris Limited is the UK affiliate of Philip Morris International. Philip Morris Limited is not a member of the Tobacco Manufacturers Association.

³⁰⁷ Health Select Committee Second Report—The Tobacco Industry and the Health Risks of Smoking ("2000 Report").

³⁰⁸ Department of Health Report on the Consultation to Introduce Picture Warnings on Tobacco Packs, August 2007, pages 9 and 11.

6. In essence, therefore, we consider it appropriate for governments and the public health community to take measures to discourage adults from smoking and to encourage tobacco manufacturers to reduce the harm caused by tobacco consumption. We support strong and effective regulation to achieve these goals and thereby support the Government in its Public Service Agreement to “promote better health and wellbeing for all”³⁰⁹ by reducing “smoking prevalence to 21 per cent or less by 2010, with a reduction in prevalence among routine and manual groups to 26 per cent or less”³¹⁰. We also appreciate the Government’s view that reducing smoking prevalence “is crucial to delivering reductions in health inequalities, and to tackle health problems in poorer communities.”³¹¹

7. The suggestions we submit below are provided in that context.

TOBACCO TAXATION

8. As part of the Government’s Public Service Agreement 18³¹², Her Majesty’s Treasury (HMT) shares the responsibility in this by “maintaining high levels of tax helps to reduce overall tobacco consumption”.

9. While we support the use of fiscal policies as an integral part of the UK’s comprehensive tobacco control programme, there is an increasing disparity in cigarette pricing between the premium and super-low cigarette price segments as a consequence of progressive tobacco tax increases. In today’s market, there is over a £1 price difference between a 20 pack of premium priced cigarette brand at £5.44 and an ultra-low priced brand at £4.28.

10. This has had the effect of encouraging consumers to switch to cheaper brands, rather than quit. To illustrate this effect, a person smoking *Marlboro* cigarettes in 2002 could have avoided all tax increases over the last four years by simply switching down to brands that pay less tax and are thus less expensive³¹³. I would like to stress that we are not advocating a reduction of taxation. Rather, we wish to express our view that the impact of consistent tax increases is not necessarily impacting upon the tax and price of cigarettes uniformly to make tobacco less affordable as the Government’s policy intends. Instead, the effect is prejudicial to both the Government’s objective of further reducing tobacco consumption and optimising fiscal revenues. For example, the size of the cigarette super-low price segment has more than doubled from 15% in 1997 to 35% in 2004.³¹⁴

11. In their 2004 Budget submission, Action on Smoking and Health (ASH) explained that, “Smokers have increasingly turned to budget brands and these have risen rapidly in market share since 1997 with economy and ultra-low price cigarettes rising from 35% to 46%.”

12. In that same Budget submission, ASH recommended that, “specific tax duties be maximized as a proportion of the total tax burden as these apply a flat rate increase to all brands and so help reduce the differential between the lower priced and premium brands.”

13. The UK Government has voiced its view that, “there is a strong case for specific duties as the only option for taxing tobacco products”.³¹⁵ While this approach may address the issue, we are concerned that it is unlikely to be supported at the European level and is certainly not a measure that could be undertaken in the near future.

14. However, we do believe that this situation can be addressed by reinforcing the specific character of the UK fiscal system—whilst respecting EU fiscal requirements. By making amendments to the tax structure, we believe that the Government can more effectively promote that smokers quit rather than trading down to cheaper brands—thus making the Government’s fiscal policy more effective in its aim to reduce tobacco consumption.

15. The Government could introduce what is known as a “Minimum Excise Tax”. The name is somewhat misleading as this measure is not an additional tax to be levied. Rather, it is a mechanism by which the Government can guarantee a minimum tax income on each pack of cigarettes and therefore stimulate a price increase of cheap cigarettes. In turn, this would reduce the potential for consumer switching to cheaper brands.

16. This system is widely used in the EU; 19 EU countries have adopted this measure, including those with tax structures similar to that of the UK such as Sweden and the Netherlands.

³⁰⁹ PSA Delivery Agreement 18: Promote better health and wellbeing for all; HM Treasury 2007 Pre Budget Report Comprehensive Spending Review: Public Service Agreements, October 2007.

³¹⁰ *Ibid.*

³¹¹ *Ibid.*

³¹² PSA Delivery Agreement 18: Promote better health and wellbeing for all; HM Treasury 2007 Pre Budget Report Comprehensive Spending Review: Public Service Agreements, October 2007.

³¹³ A pack of 20 *Marlboro* cigarettes in April 2002 had a recommended retail price (RRP) of £4.45. The current RRP of one of the cheapest brands on the market is £4.28.

³¹⁴ Chief Medical Officer’s Annual Report 2004, “Tobacco and Borders: Death Made Cheaper”.

³¹⁵ UK Government response to the Commission’s Consultation Paper on the structure and rates of excise duty applied on cigarettes and other manufactures tobacco.

TOBACCO PRODUCT REGULATION

17. We have welcomed and supported many of the Government's recent actions to encourage smoking cessation and tackle the issue of youth smoking; the recent increase in the minimum age, the current implementation of a retail licensing scheme³¹⁶, the introduction of pictorial health warnings and the provision of NHS stop-smoking services. However, as the UN³¹⁷ and others have recognized, despite the health effects of tobacco use and the best intentioned public health measures, many people will continue to use tobacco products. This view is supported by the Royal College of Physicians who recently published a report stating that there is likely to remain a "substantial number of "hardcore" smokers who have no desire or intention to quit."³¹⁸ Consequently, we believe that the Government should look to other means to also reduce the harm caused by smoking, particularly for those people who will continue to use tobacco products in the future.

18. Internationally, public debate is increasingly focusing on the issue of further regulation of the product itself. While further regulation of tobacco products is as yet an under-developed regulatory area, it has been described by the WHO Study Group on Tobacco Product Regulation ("TobReg") as of "vital importance to public health."³¹⁹ We believe that product regulation should be a central feature of comprehensive legislative frameworks addressing a broad spectrum of product issues—including ingredients, smoke emissions, tobacco blends, product design—as well as the development and marketing of products that have the potential to reduce either exposure to harmful compounds or the risk of tobacco-related diseases.

19. Currently, we hope that, through the Conference of the Parties and with the assistance of WHO TobReg, clear and specific guidance on product regulations will be provided. Meanwhile, we would hope that further steps could be taken to introduce additional product regulatory requirements beyond the current Tobacco Products (Manufacture, Presentation and Sale) (Safety) Regulations.

20. For example, we believe all tobacco manufacturers should be required to provide information on emissions of a range of mainstream smoke constituents (in addition to tar, nicotine and CO). We would advocate that the range of smoke constituents analysed should be based on established work, for example, the Health Canada list³²⁰ of mainstream smoke constituents.

21. Initiating this could help the public health authorities build a knowledge base about tobacco products which could then be used to develop and establish guidelines and standards to further support the goal of harm reduction as well as create a basis to assess innovative products that have the potential of reducing exposure to harmful compounds and/or risk of disease.

22. While we fully appreciate that product regulation is still an emerging area of focus and, as WHO says on its website, a "novel and complex area of tobacco control"³²¹, we would also like to take this opportunity to refer to the Health Select Committee 2000 Second Report, "The Tobacco Industry and the Health Risks of Smoking". In its Summary of Conclusions and Recommendations, the Committee advocated:

- (ee) Given that, because of their addiction, people will demand cigarettes for the foreseeable future, it is clearly preferable that they smoke "safer" cigarettes. We therefore hope that such products will be developed. We note the argument put forward by some of the companies that the successful marketing of such products is stymied by the regulatory framework. We recommend that the new Tobacco Regulatory Authority which we want to see established should have powers to review and approve applications from companies to market such products in a way which conveys their potential benefits compared to normal cigarettes, as long as full information about the product is provided and assessed by an independent panel of experts (appointed by the Authority), a process which should be funded—via a charge by the Authority—by the company applying. There should then be regular and rigorous reviews of the product and its effects to ensure that it deserves to retain its preferential marketing status. We would expect that status to be very narrowly defined and its promulgation strictly enforced by the Authority (paragraph 146).

³¹⁶ Amendment (NC 41)—"Persistent sales of tobacco to persons under 18" to the Criminal Justice and Immigration Bill.

³¹⁷ The 2004 United Nations Ad Hoc Inter-Agency Task Force on Tobacco Control Report of the Secretary-General stated, "Even assuming a decrease of overall prevalence at annual rate of 1 per cent, the number of tobacco users would still be expected to increase to 1.46 billion by 2025." United Nations Economic and Social Council (UN ECOSOC), E/2004/55, April 2004.

³¹⁸ Harm reduction in nicotine addiction, helping people to quit; A report by the Tobacco Advisory Group of the Royal College of Physicians, October 2007, Page 229.

³¹⁹ WHO Study Group on Tobacco Product Regulation Recommendation 1: Guiding Principles for the Development of Tobacco Product Research and Testing Capacity and Proposed Protocols for the Initiation of Tobacco Product Regulation, 2004 ("TobReg Guiding Principles"), page 8.

³²⁰ The Health Canada mainstream smoke constituent list is specified in Health Canada Tobacco Industry Reporting Regulations, Part 6, Schedule 2.

³²¹ World Health Organization, Tobacco Free Initiative, Study Group on Tobacco Product Regulation (TobReg) at http://www.who.int/tobacco/global_interaction/tobreg/en/

23. While the 2000 Report identified other issues to be addressed as regards product regulations, we particularly wish to express our support for this recommendation in relation to future potentially reduced risk tobacco products. However, we would like to emphasize that the best way to reduce the risk of tobacco-specific diseases is to prevent initiation of tobacco use and to encourage cessation, and just as clearly, the marketing of reduced exposure and reduced risk tobacco products should not deflect government efforts from the valid public health goals of preventing initiation and encouraging cessation.

24. However, we believe—as do others—that reducing the risk of tobacco use through product modification is a legitimate component of an overall harm reduction strategy.³²² As stated in an article on this subject,

“[a]lthough cessation and prevention should remain the primary methods for tobacco control, several reasons have been provided to support considering lowering tobacco toxin exposure and addictiveness as a strategy to reduce negative health consequences.”³²³

25. Put simply, if tobacco use will continue into the future, the development of safer products should be an important objective,³²⁴ and it is one we are pursuing.

ADDRESSING ILLICIT TOBACCO PRODUCTS

26. As part of the Government’s Public Service Agreement 18³²⁵, Her Majesty’s Revenue and Customs (HMRC) shares the responsibility in this through

“continued action in tackling tobacco smuggling and reducing the illicit market share of hand-rolled tobacco . . . as the availability of cheap tobacco undermines the high rate of duty on cigarettes, and has a particular effect in groups more sensitive to price—such as routine and manual workers.”

27. We agree that fiscal measures should be an integral part of the UK’s tobacco control program and we believe that it is crucial that the Government implements measures to effectively counter the illicit trade in tobacco product.

28. We welcome and continue to work with HMRC on the initiative announced by the then Chancellor in Budget 2007 to introduce “a covert security mark on packs . . . to tackle the threat from counterfeit tobacco”³²⁶. We are supportive of the Government’s aim to implement security measures but believe from our experience (particularly in relation to the Anti-Contraband and Anti-Counterfeit Agreement between Philip Morris International Inc. and the European Commission (“EU Agreement”)) that there are additional measures which can be used to effectively counter the illicit trade.

29. Such measures include extending the “positive” licensing system which currently exists for manufacture and distribution of tobacco products also to the retail of tobacco products and the implementation of systems for the tracking and tracing of tobacco products.

Licensing

30. Regarding the retail sale of tobacco products, the Government is currently implementing a “negative” licensing system—as recommended by the Committee in its 2000 Report³²⁷—through the adoption of Amendment (NC 41)—“Persistent sales of tobacco to persons under 18” to the Criminal Justice and Immigration Bill, tabled by the Rt. Hon. David Hanson MP, the Minister of State at the Ministry of Justice.

31. While we believe that the introduction of this amendment represents a real landmark in the provision of effective policy to tackle both the illicit trade and prevent youth smoking, we feel that there is an opportunity here to make even more headway in tackling these issues. We believe that the Government should take a step further through the introduction of a “positive” licensing system—rather than the “negative” licensing system that the Minister’s amendment currently provides.

32. We believe that much greater efforts should be made to ensure adherence to the legal age for the sale of tobacco products and the retail of UK duty paid products only. To achieve this, retailers should understand that failure to follow the law will result in meaningful penalties, including the loss of the right to sell tobacco products.

³²² Tobacco harm reduction has been defined as “minimizing harms and decreasing total morbidity and mortality, without completely eliminating tobacco and nicotine use.” Stratton, K.; Shetty, P.; Wallace, R.; Bondurant, S., eds. *Clearing the Smoke: Assessing the Science Base for Tobacco Harm Reduction*. National Institutes of Health, Institute of Medicine (Washington, D.C.: National Academies Press 2001) (“IOM Report”), page 25.

³²³ Hatsukami, D.K., Giovino, G.A., Eissenberg, T., Clark, P.I., Lawrence, D., Leischow, S., 2005. Methods to assess potential reduced exposure products. *Nicotine & Tobacco Research* 7(6), page 830.

³²⁴ IOM Report, page 38 (“[I]n addition to interventions aimed at prevention and at promoting immediate quitting, it is appropriate to consider interventions that aim to reduce the harm that the remaining population of smokers cause themselves and others by continued smoking.”).

³²⁵ PSA Delivery Agreement 18: Promote better health and wellbeing for all; HM Treasury 2007 Pre Budget Report Comprehensive Spending Review: Public Service Agreements, October 2007.

³²⁶ Budget 2007 Press Notice PN 3, 21 March 2007.

³²⁷ Paragraph “n”, Health Select Committee Second Report—The Tobacco Industry and the Health Risks of Smoking, January 2000.

33. Clearly, a key barrier to acceptance of this for retailers is the cost and administrative burden they will bear and, in adopting a positive licensing system, the Government should try to reduce these as much as possible.

34. Another key benefit is the ability of “positive” licensing to assist enforcement agencies such as Trading Standard authorities by generating additional funds to cover the costs associated not only with administration, but enforcement of the minimum age law and/or the Government’s anti-smuggling strategy.

35. Importantly, this approach of positive licensing has also been supported by the Royal College of General Practitioners (RCGP)³²⁸, the British Heart Foundation³²⁹, Action on Smoking and Health (ASH)³³⁰, Cancer Research UK³³¹ and the British Medical Association³³².

Tracking and Tracing Protocols

36. It is important that Governments have the ability to track and trace sales of cigarettes. Through the protocols of the EU Agreement, Philip Morris International routinely provide the Anti-Fraud Office of the European Commission (OLAF), and nominated officers within signatory Members States, with full time access to an on-line database that can be used to identify the first purchaser and, for certain markets, subsequent purchasers of our products. In this fashion, authorities can track the movement of our cigarettes through the supply chain and potentially trace back to the point where product has been diverted from legitimate trade channels.

37. Action on Smoking and Health (ASH) have “urged HM Treasury and HMRC to sign up to” the Agreement and have specifically recognized the ability to track and trace as a crucial element of the Agreement by stating,

“tracking and tracing protocols giving Customs 24 hour online access to the database, allowing Customs to independently identify smuggled cigarettes so they can be traced back to the contractor which bought them from Philip Morris International”³³³.

38. Within the Agreement there are elements that create procedures for the sharing of information related to the illicit trade, PMI technical analysis of seized products and pack and carton labelling detailing production and intended market for sale information. All of these efforts are applicable to fighting both contraband and counterfeit cigarettes.

CONCLUSION

39. Thank you for the opportunity to present our views. We would be very pleased to provide the Committee with further details on these and any other issues relating to the regulation of tobacco products. We would also like to take this opportunity to offer our assistance from our international experience in both explaining the potential implications of such measures as well as provide insight into how these issues have been addressed in other parts of the world.

January 2008

Memorandum by the Royal College of Midwives (RCM) (HI 44)

HEALTH INEQUALITIES

1. EXECUTIVE SUMMARY

1.1 Maternity services have a key role to play in reducing health inequalities, and they can do so right at the start of life. No other service offers such an early opportunity to tackle some of the most fundamental inequalities.

1.2 Inequalities apparent in pregnancy are some of the widest and bleakest: mothers and children are more likely to die or to suffer illnesses simply because of their background.

1.3 Midwives can play a vital role, but currently they are being held back by a range of factors, mostly relating to capacity issues.

1.4 The RCM proposes some recommendations, particularly about ensuring all women can access maternity care early so that their needs can be identified and their care tailored to the needs.

³²⁸ As reported in the Department of Health Consultation Report on Changing the Age of Sale for Tobacco, Feb 2007, page 6 (point 15).

³²⁹ *Ibid.*

³³⁰ *Ibid.*

³³¹ *Ibid.*

³³² British Medical Association report “*Breaking the cycle of children’s exposure to tobacco smoke*”, April 2007, pg 42.

³³³ Action on Smoking & Health (ASH) 2007 Budget Submission.

2. THE ROYAL COLLEGE OF MIDWIVES

2.1 The RCM represents over 95% of all the UK's practising midwives, with over 35,000 members. It is the world's oldest and largest midwifery organisation. It works to advance the interests of midwives and the midwifery profession and, by doing so, enhance the wellbeing of women, babies and families.

3. MATERNITY SERVICES: AN OPPORTUNITY TO TACKLE HEALTH INEQUALITIES

3.1 Maternity services are an unmissable opportunity to tackle health inequalities.

3.2 Firstly, maternity services are there right at the start of life. Maternity services represent the earliest possible opportunity to lay the best foundations for good health. Moreover, and very importantly, inequalities at this stage get locked in. Not tackling such inequalities therefore fundamentally undermines any focus on tackling them later on.

3.3 Secondly, and referred to above, it is a time when some simple steps can have a big impact. Breastfeeding, for example, can give newborns an excellent start in life, and parents choosing to stop smoking will improve their own health and that of their children. Decisions taken at this time can have an enduring effect.

3.4 Thirdly, maternity services that work well potentially pay dividends twice: once in the health of the newborn baby and again in the health of the mother. Maternity services are used by women when most are still at a relatively young age. 57% of all live births in England in 2005, for example, were to women aged 30 or under at the time of birth (348,658 out of 613,028)³³⁴. This period is therefore a window of opportunity to tackle inequalities that have persisted into adulthood.

3.5 Fourthly, and linked to the paragraph above, maternity services are accessed by a large number of women. There were 639,666 live births and stillbirths in England in 2006, for example³³⁵.

3.6 Fifthly, women from every background use maternity services. Midwives therefore come into contact with women from every kind of background and so are in a position to address issues of health inequalities.

3.7 Finally, it is not a service where contact between the service user and the NHS is over quickly, like for example treatment in A&E or a single GP appointment. Midwives are likely to have contact with the mother over an extended period of time. This potentially offers ample opportunity to identify those mothers with particular needs and to address those needs.

3.8 In summary therefore maternity services offer a window of opportunity in the drive to tackle health inequalities. This is because during pregnancy large numbers of relatively young women from all backgrounds will potentially be in prolonged contact with midwives at a time when they can make decisions that will benefit not just their health but also the health of their newborn baby and the future family.

4. INEQUALITIES SEEN IN MATERNITY SERVICES

4.1 The starkest inequality in maternity services is in relation to maternal deaths. Put simply, some women are more likely to die than others.

4.2 Every three years, the Confidential Enquiry into Maternal and Child Health (CEMACH) publishes a study into maternal deaths and their causes. Their latest report³³⁶, published in December 2007 and covering the 2003–05 period, uncovered some very bleak findings (unless stated, statements refer to the United Kingdom as a whole):

- Black African women (including asylum seekers and recent refugees) were nearly six times more likely to die than women who were white. The mortality rate was also “significantly higher” for Black Caribbean and Middle Eastern women than for white women.
- Women whose partners were jobless were up to seven times more likely to die than women whose partners were in work.
- In England, women living in the most deprived areas were five times more likely to die than women living in the least deprived areas.
- A third of women who died were single and jobless, or they were in a relationship where both partners were without jobs.
- 14% of those who died had declared that they suffered from domestic violence.
- 11% had substance abuse problems, with 60% of those being registered addicts.
- A tenth lived in families known to the child protection services.

³³⁴ Statistics on births broken down by age of mother at time of birth provided in answer to a Parliamentary Question from Andre George MP, House of Commons Hansard, 13th November 2007, c200–02W.

³³⁵ Live birth statistics provided in answer to a Parliamentary Question from Andrew George MP, House of Commons Hansard, 25th June 2007, c362–64W. Stillbirth statistics provided in answer to a Parliamentary Question from Mark Lancaster MP, House of Commons Hansard, 13th December 2007, c819–20W.

³³⁶ Confidential Enquiry into Maternal and Child Health (2007) *Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer—2003–2005*.

4.3 CEMACH also found that the women who died who had socially complex lives were “far less likely” to seek out maternity care early in their pregnancy, or to stay in regular contact with maternity care professionals.

4.4 The Department of Health clearly accept the scale of the problem. They state in the document setting out their *Maternity Matters* strategy for maternity services that “outcomes of pregnancy for the more vulnerable and disadvantaged are cause for concern”³³⁷.

4.5 The strategy further sets out the scale of the inequalities in pregnancy:

- An estimated 30% of domestic violence cases start or escalate during pregnancy, and that such violence is associated with miscarriages, low birth weight, premature birth, fetal injury, and fetal death.
- Rates of infant mortality are higher among routine and manual socio-economic groups, and that higher than average death rates occur among black and minority ethnic babies, the babies of teenage mothers and those registered at birth by one parent rather than two. Babies born in the most deprived areas are up to six times more likely to die in infancy.
- Mothers under 18 years of age are more likely to delay accessing maternity care until they are five or more months pregnant, with worse outcomes than those who access care earlier.
- Teenage mothers are three times more likely to smoke than older mothers.

4.6 Earlier, in 2004, the National Service Framework for Children, Young People and Maternity Services (the Children’s NSF) warned: “Women living in disadvantaged or minority groups and communities are significantly less likely to access services early or maintain contact throughout their pregnancies. They are also less likely to breastfeed. In consequence, the outcomes for their own and their babies’ health and wellbeing are worse than for the population as a whole.”³³⁸

4.7 On breastfeeding, the Children’s NSF noted that women from lower socioeconomic groups are less likely to breastfeed than others, and teenage mothers are half as likely to breastfeed as older mothers.

4.8 So, not only do maternity services offer an opportunity to intervene, for reasons explained above, but the starkness and bleakness of the inequalities in outcomes in pregnancy present a compelling moral case further to prioritise tackling these inequalities at this vital stage.

4.9 As Sheila Shribman, the National Clinical Director for Children, Young People and Maternity Services, has passionately stated, “It is unacceptable . . . that some pregnant women in our advanced western society are more at risk than those in parts of the developing world.”³³⁹

5. WHAT IS HOLDING MIDWIVES BACK?

5.1 Maternity services therefore have a real role to play in ironing out health inequalities. Unfortunately however several factors are holding the service back from delivering on its full potential.

5.2 Firstly, priority has not been given to maternity services over the last 10 years when it has come to deciding the NHS budget. In 1997–98, for instance, maternity services absorbed 3.1% of the NHS budget in England, but by 2006–07 this had fallen to 2.0%. Indeed, total spending on NHS maternity services in England actually fell by £55 million in the last financial year for which figures are available (2006–07)³⁴⁰.

5.3 Additionally, Payment by Results (PbR) is having an (unintended) effect on maternity services. Currently, funding for maternity care delivered in maternity units is paid for under PbR. This means that activity generates revenue. Maternity care delivered in the community, such as midwife-led antenatal care, antenatal classes and postnatal visits, are paid for through a block grant. That means that more activity does not generate more revenue. As a result, much of the work that could be directed at focussing on those most in need of additional assistance is not rewarded by funding mechanisms. PCT block contracts are also under pressure, with no penalty for reducing maternity care activity levels.

5.4 This PbR anomaly also exacerbates the problem that the focus of maternity care is increasingly based around the hospital and around birth, and decreasingly around care delivered during pregnancy and in the community. It is during pregnancy and in the community that midwives will be able to have most effect in terms of addressing inequalities, not when they are under the pressure and demands of a busy maternity unit.

5.5 Secondly, and linked to the paragraph above, midwives lack a readily identifiable community base that women can easily drop in to. This heightens the barrier between the woman and the midwife, perhaps discouraging the woman from seeking maternity care as early as she needs to.

³³⁷ Department of Health (2007) *Maternity Matters: Choice, access and continuity of care in a safe service*.

³³⁸ Department of Health (2004) *National Service Framework for Children, Young People and Maternity Services*.

³³⁹ Department of Health (2007) *Making It Better: For Mother and Baby. Clinical case for change. Report by Sheila Shribman, National Clinical Director for Children, Young People and Maternity Services*.

³⁴⁰ Statistics on NHS spending have been taken from answers to two Parliamentary Questions. Figures for 1997–98 — 2005–06 appeared in answer to a Parliamentary Question from John Baron MP, House of Commons Hansard, 6th March 2007, c1954W. Figures for 2006–07 appeared in answer to a Parliamentary Question from Mike Hancock CBE MP, House of Commons Hansard, 12th November 2007, c59–60W.

5.6 Thirdly, staffing increases in the NHS overall have largely passed midwifery by. Both the full-time-equivalent number of midwives in England's NHS fell in the last annual staffing snapshot (down 87 between 2005 and 2006) and the headcount number fell at both of the last two counts (down 375 between 2004 and 2006)³⁴¹.

5.7 Finally, England is witnessing a rapidly rising birth rate. In the five years between 2001 and 2006 the total number of births increased by 13% (an extra 71,935 babies annually)³⁴². Combined with the shrinking workforce, the number of births in England per full-time-equivalent midwife rose at the last count (September 2006) from 32 to 33, with regional variations from 27 (in the North West) to 43 (in South Central)³⁴³.

5.8 These stresses are impacting in many different ways on the quality of maternity services delivered to women.

5.9 In its study of women's experiences of maternity care in the NHS in England, published in November 2007, for example, the Healthcare Commission³⁴⁴ found that:

- Of those women who had seen a midwife for their antenatal checkups, 43% had not seen the same midwife "every time" or "most of the time".
- 36% of women who wanted to attend an NHS antenatal class said they were not offered a place on one. For first-time mothers the figure was 14%.

5.10 Clearly, women are not currently receiving the first-class maternity service that they deserve, and with the service, and particularly antenatal care, underperforming in this way it seems unlikely that midwives will be able to deliver the kind of personalised care needed to tackle inequalities.

6. RECOMMENDATIONS

6.1 The RCM is not only going to recommend more investment and more midwives, but these are vital if we are to tackle inequalities successfully.

6.2 As set out above, not only the share of the NHS budget spent on maternity but the actual sum of money spent on NHS maternity services is down. NHS maternity services in England received £55 million less in 2006–07 than in 2005–06, despite a rising NHS budget overall and a rising birth rate. This must be reversed.

6.3 At the same time, the number of midwives in the NHS in England, expressed as a simple headcount or on a full-time-equivalent basis, is down. The hard work of tackling health inequalities, and at such a crucial time as pregnancy and birth, cannot be undertaken successfully by a midwifery workforce that is shrinking just as the number of babies born is rising fast.

The RCM will not only recommend more investment and more midwives, but more investment and more midwives are needed now.

6.4 A recurrent theme in the evidence of inequality in pregnancy is accessing maternity care late in pregnancy. This is absolutely fundamental because if the woman is not in the system and not accessing maternity care then everything else is of no significance. Maternity care could be the best in the world, but if a woman is accessing it late then she will have missed out. Additionally, the shorter the period of time for which the midwife will be caring for the woman the less time she has to work with the woman and tailor the care she gives to the needs the woman has.

6.5 We welcome the performance indicator on early access to maternity services included in the new *Better Care for All* Public Service Agreement, announced in the autumn. This will measure the percentage of pregnant women who, by the twelfth week of pregnancy, have been seen by a midwife or other maternity healthcare professional.

6.6 The next step is of course how to make that happen. To improve early access to maternity care, Southampton PCT reorganised its services, according to report by Sheila Shribman, the National Clinical Director for Children, Young People and Maternity Services³⁴⁵. Midwives work with community workers, Sure Start children's centres, interpreters, social services and GPs. Peer groups are used to support breastfeeding.

6.7 This kind of outreach work is very important, and to complement it, midwives need a base in the community. Women need to know where they can easily find a midwife and access maternity care. The obvious place for them is in children's centres.

³⁴¹ Staffing statistics provided in answer to a Parliamentary Question from Anne Milton MP, House of Commons Hansard, 29th October 2007, c1044–46W.

³⁴² Birth statistics provided in answer to a Parliamentary Question from Andrew George MP, House of Commons Hansard, 25th June 2007, c362–64W.

³⁴³ Information provided in answer to a Parliamentary Question from Norman Lamb MP, House of Commons Hansard, 18th December 2007, c1374–75.

³⁴⁴ Healthcare Commission (2007) *Women's experiences of maternity care in the NHS in England*.

³⁴⁵ Department of Health (2007) *Making It Better: For Mother and Baby. Clinical case for change. Report by Sheila Shribman, National Clinical Director for Children, Young People and Maternity Services*.

6.8 Government policy on this was reiterated recently: “All Sure Start children’s centres should link to maternity services. The Government’s Practice Guidance (2006) for local authorities and the health service says that in the most disadvantaged areas we expect to see midwives working from Sure Start children’s centres, or having strong links with centres.”³⁴⁶

6.9 This is not enough. Official guidance should be that midwives should be based in every children’s centre.

6.10 The advantage of this would not just be felt by midwives, but by every service using children’s centres. This is because basing midwives in children’s centres would bring into the centres women who are pregnant. They could then very easily find out about all the other services that the children’s centre offers. If pregnant women can access information and help with such things as good parenting, budgeting, and healthy eating, then those are lessons they will hopefully have learnt before the baby is born, not afterwards. Moreover, if there are lessons that help the woman herself improve her own health, through for example eating a healthier diet, then the earlier change can occur the better. Bringing women in earlier can only help.

6.11 There are also other locations where midwives could be based, at least at certain times of the week. Midwives in Kent, for example, run an antenatal clinic in a Sainsbury’s supermarket in Broadstairs³⁴⁷. It is open every Thursday from 8am until 10pm. The supermarket has free parking, plus pregnant women can use the bus service to and from the clinic free.

6.12 With reconfigurations occurring right across England, we need also to be sure that in the event of a unit closing there is something useful left behind. If a unit closes and the remaining nearest unit is many miles away, it is those disadvantaged women who will no doubt find it hardest to access.

6.13 Where a consultant-led unit is closed and a midwifery unit left in its place, for example, perhaps a medically-led clinic could be held onsite once a week or once a fortnight. Those needing medical supervision could therefore continue to attend appointments locally, without the demands on the local NHS of the unit offering 24-hour medical cover, or local women facing the cost and time of travelling.

6.14 Wherever midwives are based and whatever facilities are offered however there needs to be comprehensive local “signposting”—in GP practices, in pharmacies, on the NHS website, in local newspapers, and so on. Not only that however. Outreach work of the type identified above is needed too. Pregnant women need to know as early as possible how and where to access maternity care.

6.15 All this needs also to be recognised in the financial systems within the NHS. This must be a priority as PbR is developed.

6.16 Improving rates of early access to maternity care is hard work. The Government’s PSA performance indicator will no doubt prove helpful, but we need to see committed action locally to make early access a reality not just for most women, but for all women.

6.17 Breastfeeding is also a specific issue that needs to be addressed. Breastfeeding has positive health benefits for the newborn baby, and this is recognised by the Government³⁴⁸.

6.18 As spelt out above however rates of breastfeeding are known to be lower amongst disadvantaged or minority groups and communities, amongst those from lower socioeconomic groups, and amongst teenage mothers. This reinforces existing health inequalities experienced by their children.

6.19 To close the inequality gap, breastfeeding needs proactive promotion amongst these groups.

6.20 The Children’s NSF progress report, published in November 2007, illustrated how this has happened in Lancashire, with dedicated support for those finding it hard to breastfeed³⁴⁹. The percentage of women breastfeeding at six-eight weeks has risen from 20% to 56%.

6.21 A similar approach needs to be taken with smoking during pregnancy. As noted above, this is more prevalent amongst pregnant teenagers than amongst older pregnant women.

6.22 Maternity services have a key role to play in reducing health inequalities, and they can do so right at the start of life. No other service offers such an early opportunity to tackle some the most fundamental inequalities.

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³⁴⁶ This is part of the answer given by the Rt Hon Beverley Hughes MP, Minister of State for Children, Young People and Families to a Parliamentary Question from Mike Hancock CBE MP, House of Commons Hansard, 18th December 2007, c1259W.

³⁴⁷ A report on this clinic is available online, at Guardian Unlimited, the URL of which is <http://www.guardian.co.uk/society/2007/oct/31/guardiansocietysupplement.health>.

³⁴⁸ An example of the kind of endorsement given by ministers to breastfeeding is given in answer to a Parliamentary Question from the Rt. Hon. Keith Vaz MP, House of Commons Hansard, 18th July 2005, c1455W.

³⁴⁹ Department of Health (2007) *Children’s health, our future: A review of progress against the National Service Framework for Children, Young People and Maternity Services 2004*.

Memorandum by Heart of Mersey (HI 45)

THE CONTRIBUTION OF THE NHS TO REDUCING HEALTH INEQUALITIES

HEART OF MERSEY

Heart of Mersey (HoM) is a cardiovascular disease (CVD) prevention charity primarily funded by the primary care trusts and local authorities across Greater Merseyside. HoM aims to co-ordinate a strategic approach to preventing the high rates of cardiovascular disease and associated inequalities in Greater Merseyside. Heart of Mersey is working to achieve its aim through advocacy, campaigns, information and research. HoM works in partnership with a wide range of partners to achieve its aims.

HoM focuses on improving nutrition and reducing the harm from tobacco as the key modifiable lifestyle factors in reducing not only CVD but other noncommunicable diseases such as cancer, diabetes and chronic respiratory disease.

Greater Merseyside suffers disproportionately from health inequalities with deaths from CVD around 25% higher than the average figure in England.

EXECUTIVE SUMMARY OF SUBMISSION:

Heart of Mersey believes that the NHS must engage with other organisations—such as local authorities—in order to address health inequalities. A population-based approach to prevention is more effective than focusing on a number of individuals at high risk of poor health. The role of government in tackling health inequalities is critical as appropriate legislation is essential to support the development of healthier environments where healthier lifestyle choices are made easier. Marketing campaigns which focus on changing the lifestyles of individuals in isolation, are likely to increase health inequalities. The development of the government's stewardship role (Nuffield Council on Bioethics) is encouraged.

1. *The extent to which the NHS can contribute to reducing health inequalities, given that many of the causes of inequalities relate to other policy areas eg taxation, employment, housing, education and local government;*

1.1 The NHS has a limited capacity to directly contribute to reducing health inequalities, as its focus is primarily on treating patients. However, the sections of the NHS (such as within primary care trusts) which are dedicated to public health, health improvement and health promotion have a key role to play in supporting wider efforts to reduce inequalities through advocacy and forming effective partnerships with other key partners such as local authorities through effective local area agreements.

1.2 In addition legislation has been shown to be a powerful tool to bringing about effective behaviour change which can improve health, for example the seatbelt legislation, and more recently, smokefree legislation in the UK. Achievement of comprehensive smokefree legislation—ie without exemptions for places that may have left more deprived communities unprotected—though the Health Act in England demonstrated that the NHS working in partnership with other public sector bodies, community and voluntary groups and businesses is critical to effect policy change at a population level that will not widen inequalities.

1.3 Similarly, relevant parts of the NHS must be actively involved in advocating for legislation to support policies which will support improvements in lifestyles, particularly among the more disadvantaged sections of the population. Policies that now require this approach include:

- The Common Agricultural policy in Europe, which, through its influence on food production, availability and prices in Europe, and has contributed to the widespread availability and consumption of cheap saturated fat in the form of excess beef and dairy products. It has also led to subsidies for the cheap disposal of surplus products such as butter and full fat milk to schools. This policy needs to be revised to support production of health-promoting foods and unsaturated fats, consumption of which will contribute to a reduction in poor diets (FPH 2007). The Department of Environment, Food and Rural Affairs (DEFRA) should also be encouraged to do its bit to support this agenda and strengthen the links and partnership working between agriculture and health for the good of the UK population.
- The Healthcare Commission's assessments of NHS trusts should include specific targets on local food procurement, provision of health-promoting food to staff and patients, as well as other opportunities to promote healthier lifestyles.

1.4 The NHS should be willing to engage with the Third Sector—where appropriate—both in the delivery of services but also to seek to influence key sectors with transport, housing and education for example.

2. *The distribution and quality of GP services and their influence on health inequalities, including how the Quality and Outcomes Framework and Practice-based Commissioning might be used to improve the quality and distribution of GP services to reduce health inequalities;*

2.1 In Cheshire & Merseyside, a guide for practice based commissioners has been produced to improve outcomes in cardiovascular disease. This should impact on the quality of GP services and help to address health inequalities in clinical management for patients with CVD for example.

2.2 Smoking is a major cause of premature death and ill health. The links between smoking and cancer, heart disease and stroke are well documented. Merseyside in particular has some of the highest smoking rates in the country, particularly in the most deprived communities. GP services are important in the provision of and referral to Stop Smoking Services. The Quality Outcomes Framework (QOF) already makes provision for GP practices to support smokers to quit, with attached payment. Ensuring that GP services identify smokers and offer referral stop smoking interventions, be this practice based, community based or telephone, and that those services are appropriate and easily accessible, is essential.

3. *The effectiveness of public health services at reducing inequalities by targeting key causes such as smoking and obesity, including whether some public health interventions may lead to increases in health inequalities; and which interventions are most cost-effective;*

3.1 Reducing income inequalities and addressing relative deprivation is likely to be effective in reducing inequalities in CVD. The focus should be on restoring opportunities and reasons for optimism for the whole of society, including the poor and socially excluded. Social, economic, health and environmental policies need to be fully integrated, and economic policies—such as regeneration—must take account of their health implications.

3.2 Engagement with the “non health” parts of the public sector to enable them to appreciate their impact on health and wellbeing is essential eg, housing, planning etc. Health impact assessments should be applied to major planning applications and infrastructure changes such as road builds or improvements.

3.3 Appropriate legislation can be a cost-effective and effective mechanism for tackling inequalities. Relevant legislation required includes:

- A comprehensive pre-9pm watershed ban on advertising on unhealthy products to children. The current ban introduced by Ofcom is a start, but does not go far enough as a large proportion of children remain unprotected at present (Hastings *et al* 2003).
- A Common Agricultural and Fisheries Policy as stated previously, which supports and promotes the production of health-promoting foods in Europe and the UK, such as fruit and vegetables, fish, unsaturated oils such as olive and rapeseed oils which are good for the heart, and grains and cereals for human consumption (FPH 2007).
- Legislation to promote the adoption of traffic light food labels by all food manufacturers. The traffic light system has consistently been shown to be the preferred system of labelling among people from more deprived backgrounds (Food Standards Agency www.food.gov.uk). However, so far, uptake of the system has been led by the retailers with a more affluent clientele such as Waitrose and Sainsbury's, while budget supermarkets which are popular with people from more deprived communities such as Aldi and Lidl have not adopted the system.
- Comprehensive nutritional standards for food provision in the pre-school sector is needed, in a similar way to the standards which are currently available for primary and secondary schools. In addition, the National Health Schools Programme should be likewise extended to pre-schools. The current lack of action for the improvement of diets of children in this age-group is a missed opportunity to shape the diets of young children from an early age (HoM 2006).

3.4 Interventions to engage with smokers in Merseyside and support them to quit have more recently included integrated social marketing approaches to support behaviour change. There is real potential for this type of public health approach to engage with deprived communities. In particular, Knowsley and Liverpool PCTs, where smoking prevalence and deprivation are high, have been leading the way nationally in the use social marketing techniques to target audiences and provide tailored services and their four week quit rates have demonstrated the success of this approach.

3.5 We believe that an upstream population-based approach (McKinlay 1998) is the most cost-effective for addressing and reducing CVD prevalence and health inequalities. The downstream approach, whilst beneficial and effective for patients with recognised CVD, evidence indicates that this medical approach is responsible for a surprisingly small proportion of CVD deaths that occur in the total population (Unal *et al.* 2005). Furthermore, evidence exists that this is not a cost-effective method for reducing CVD prevalence (Kaplan & Ong 2007; Daviglius *et al.* 2006). Large reductions in CVD prevalence can be achieved only by a reduction in the population levels of multiple risk factors and this requires a “population-based approach”. However, in order to provide “communities” with the opportunity to make changes in their lifestyle to reduce risk factors, it is necessary to have a supportive environment and public policies (both directly related to health affecting the wider determinants) to enable the “healthy choice to become the easy choice” (Rose & Lewis 1991).

4. *Whether specific interventions designed to tackle health inequalities, such as Sure Start and Health Action Zones, have proved effective and cost-effective;*

4.1 Heart of Mersey itself is an example effective collaboration in Greater Merseyside (Lloyd-Williams 2008). Originally funded by the Merseyside Health Action Zone (along with the Cheshire & Merseyside Public Health Partnership), Heart of Mersey represents a population-level strategic approach to address the high levels of cardiovascular disease in this region. The programme is principally funded by the five primary care trusts and six local authorities of Greater Merseyside.

4.2 The Cheshire & Merseyside Public Health Partnership (ChaMPs) Social Marketing Group's work in Sure Start areas working with younger children to encourage greater consumption of fruit and vegetables is of interest.

5. *The success of NHS organisations at co-ordinating activities with other organisations, for example local authorities, education and housing providers, to tackle inequalities; and what incentives can be provided to ensure these organisations improve care*

6. *The effectiveness of the Department of Health in co-ordinating policy with other government departments, in order to meet its Public Service Agreement targets for reducing inequalities; and*

6.1 The successful implementation of smokefree legislation provides a good example of how the Department of Health can work with other departments in co-ordinating policy change. However this cross-department working must now be demonstrated in other areas which will impact on reducing inequalities, for example in developing strategic partnerships with HMRC, DWP and others in the new challenge of reducing availability of counterfeit and illicit tobacco. Without a comprehensive approach to this issue, efforts to reduce smoking in routine and manual worker groups will be undermined because smuggled and counterfeit tobacco is cheap and often perceived as a "Robin Hood" enterprise. There remains much work to do on this complex issue and cross-governmental leadership would improve prospects for success.

6.2 Similar arguments can be made in the importance of DH and DeFRA working together in essential reform of the Common Agricultural Policy to reflect public health concerns—see 1.3 and 3.3 above.

7. *Whether the Government is likely to meet its Public Service Agreement targets in respect of health inequalities.*

We do not believe the PSA targets will be met on current predictions. However with sustained investment in the most successful targeted and population level public health interventions to date, we believe progress can be accelerated. In this respect I would urge the committee to consider:

1. Heart of Mersey's work as an excellent example of a population level advocacy organisation providing up-stream activity;
2. PCTs within Merseyside who have developed innovative ways to address the health inequalities challenges;
3. The importance of the government developing its stewardship role (Nuffield Council on Bioethics 2007) to provide an appropriate environment for healthier lifestyles which includes the development of legislation where appropriate in order to better address its targets in respect of health inequalities.

January 2008

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Memorandum by Roche Products Ltd (HI 46)

HEALTH INEQUALITIES

1. INTRODUCTION

1.1 Roche Products Ltd is a major producer of innovative medicines for a variety of medical conditions, including cancer, kidney disease, autoimmune disorders, osteoporosis, obesity and hepatitis C.

1.2 Unfortunately health inequalities remain a significant challenge in many of the conditions in which we have an expertise. We collect a great deal of data and intelligence on different aspects of primary care services which we believe can contribute to more informed policies to tackle health inequalities and we therefore welcome the opportunity to submit evidence to this inquiry.

1.3 Health inequalities can manifest themselves in a number of ways, including:

- Variations in a person's likelihood of developing a medical condition
- Variations in a person's health outcomes once they have developed a condition
- Variations in a person's experience of health services

1.4 These variations may depend on factors such as their geographical location, social class, ethnicity, age or gender. We would welcome recognition by the Committee of the different kinds of health inequality that exist and the different ways in which these can manifest themselves. Different interventions will be required to address these variations. Our response focuses on:

- The extent to which the NHS can contribute to reducing health inequalities
- The distribution and quality of GP services and their influence on health inequalities
- The effectiveness of public health services at reducing inequalities

2. THE EXTENT TO WHICH THE NHS CAN CONTRIBUTE TO REDUCING HEALTH INEQUALITIES

2.1 A key challenge to our ability to effectively tackle health inequalities is collecting high quality evidence about the form which inequalities take and the interventions which are most effective in addressing them. In the field of cancer, evidence is continuing to develop about the nature of inequalities. For example, an analysis by the Men's Health Forum has shown that, for the ten commonest cancers which affect both men and women, age standardised mortality rates are in every case higher in men.³⁵⁰ Yet the reasons for this remain poorly understood. We therefore welcome the Department of Health's commitment to establish a National Cancer Equality Initiative, bringing together key stakeholders from the professions, voluntary sector, academia and equality groups to develop research proposals on cancer inequalities, test interventions and advise on the development of wider policy. We would welcome a recommendation from the Committee that this initiative should be replicated for other conditions.

2.2 The Inquiry's terms of reference rightly states that there are many wider social determinants of health inequalities which it will be difficult for health services alone to influence. Factors such as housing, income inequality and education play a particularly important role in determining variations in a person's likelihood of developing a medical condition. However, preventative health services for conditions such as obesity or smoking clearly have a vital role to play in tackling inequalities.

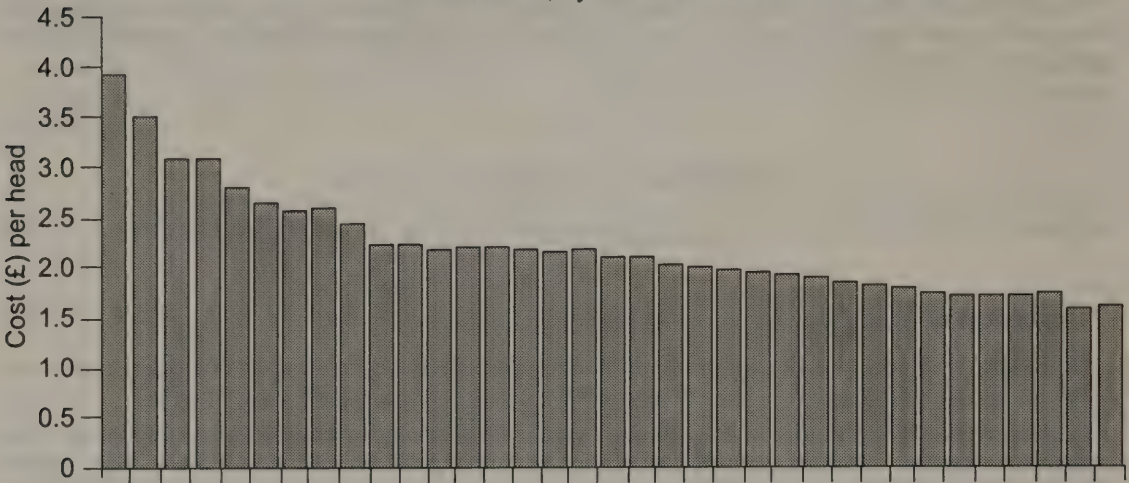
2.3 Equally, the role of health services will be central to reducing unnecessary variations in a person's health outcomes once they have developed a condition and their overall experience of health services.

2.4 For example, ensuring that every person has prompt access to clinically and cost effective treatments, irrespective of geographical location, age or ability to pay is a vital element of reducing variations in clinical outcome. Roche collects a great deal of data on access to medicines for conditions such as cancer. Unfortunately significant inequalities remain in access to these medicines, even when NICE guidance has

³⁵⁰ Men's Health Forum, Men and Cancer, 2004 Briefing Paper
http://www.menshealthforum.org.uk/uploaded_files/mhw04briefing.pdf

been available for some time. We welcome the recognition by the Department of Health in the recent Cancer Reform Strategy that significant variations remain in access to NICE-approved cancer medicines and the commitment to continue to monitor and where necessary address these.³⁵¹

Figure 17: Estimated cost per head of NICE-approved cancer drugs used in hospitals in Jan-Jun 2005, by cancer network



Method: Calculations based on volumes dispensed (from IMS-Health) and on lowest list prices for each NICE-approved cancer drug.

2.5 We have evidence that these variations also exist in other disease areas, including rheumatoid arthritis, osteoporosis and hepatitis C. Tackling such variations will be important in addressing inequalities in health outcome. We would welcome recognition by the Committee of the continuing issue of variations in access to treatment and the importance of addressing this as part of wider efforts to tackle health inequalities.

3. THE DISTRIBUTION AND QUALITY OF GP SERVICES AND THEIR INFLUENCE ON HEALTH INEQUALITIES

3.1 In recent months there has been a great deal of welcome scrutiny of the distribution and quality of GP services. We believe that it is important that access to wider primary care services is also considered as groups such as pharmacists and community nurses can play an important role in tackling health inequalities.

3.2 In relation to GP services, “levers” such as the Quality and Outcomes Framework (QOF) and practice based commissioning (PBC) offer significant opportunities to incentivise further action to address health inequalities.

Quality and Outcomes Framework

3.3 The QOF is the annual reward and incentive scheme which operates as part of the General Medical Services contract. Introduced in April 2004, it contains a series of performance-based indicators for practice organisation and management and a range of evidence-based clinical disease areas. These indicators are designed to encourage GPs to deliver high-quality care for patients with chronic conditions by measuring practice achievement against these indicators, and calculating payments based on the number of points achieved.

3.4 As of April 2006 the QOF contained 1,000 points across 136 indicators and measures. There are currently 19 clinical areas consisting of 80 indicators. The vast majority of GP practices participate in the QOF, and a significant majority achieve a high degree of QOF compliance. In 2006–7, practices in England achieved an average 95.5% of the total 1,000 points available.³⁵² The QOF system is measured through the Quality Management Analysis System (QMAS), part of NHS Connecting for Health, which collects data on practice achievement against the QOF indicators and records changes in disease prevalence. We would welcome recognition by the Committee of the proactive way in which the profession has responded to the introduction of the QOF, changing clinical practice to reflect the priorities and incentives agreed. This progress should now be built on.

³⁵¹ DH, Cancer Reform Strategy, 2007.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081006

³⁵² The Information Centre
<http://www.ic.nhs.uk/statistics-and-data-collections/audits-and-performance/the-quality-and-outcomes-framework-qof/the-quality-and-outcomes-framework-qof-2006-07>

3.5 The almost universal application of the QOF in practices across the country has had a significant impact on focusing GPs' attention on specific public health priorities. Evidence shows that QOF has driven the development of more systematic care across high prevalence disease areas leading to increased treatment rates and improved patient care for long term conditions. In the long term, we believe this will have a positive impact on health inequalities. We would welcome recognition by the Committee of the positive effect that QOF has had on standards of clinical practice.

3.6 However, the prescriptive nature of the QOF has led to concerns that attention may be diverted from those conditions which are not included in the list of clinical indicators. Therefore we believe that it is vital that the QOF continues to evolve, encompassing new clinical indicators and incentivising continuous improvements in clinical practice. Concerns have been expressed that discussions about revisions to the QOF for April 2008 appear to have been delayed. We believe any move away from an annual review, leading to the inclusion of new indicators, would be extremely detrimental to ongoing efforts to improve clinical quality. We would welcome a recommendation by the Committee that discussions on revisions to the QOF should be prioritised and should not fall victim to any wider debates between the Government and that British Medical Association.

3.7 The process for determining the inclusion of indicators in the QOF is currently complex and difficult to access for many patient groups. Although welcome improvements have been made to the transparency and accessibility of the expert review process, we believe further changes could be made.

3.8 We welcome the fact that the expert submission process requires a demonstration of the impact that any indicator would have in tackling health inequalities. However, it is unclear what influence this has on the later negotiating stages. Inclusion in the QOF should be based on evidence, need and ability to deliver on national health priorities alone. We would welcome a recommendation from the Committee supporting this approach.

Using the Quality and Outcomes Framework to improve access

3.9 There have been some suggestions that points should be taken from the clinical domain of the QOF and allocated towards extending GP opening hours. We would strongly urge against this approach:

- The clinical domain has proved to be highly successful in incentivising better clinical care, based on high national minimum standards. As mentioned above, the QOF needs to continue to evolve, thereby encouraging a process of continuing improvement. Any reduction in the relative importance of the clinical domain would compromise this.
- It is difficult to see how a reallocation of points could effectively incentivise large scale changes in extended access to GP services. Rather, it would reward those GPs who already have longer opening hours, without delivering a significant increase in accessibility in deprived areas and amongst hard to reach groups.

3.10 We would therefore welcome a recommendation from the Committee that the relative importance of the clinical domains should be at least be maintained, as part of wider efforts to increase clinical excellence and the delivery of primary care according to national minimum standards.

Example—the exclusion of osteoporosis from the Quality and Outcomes Framework

3.11 One disease area which we have been examining as a potential candidate for inclusion in the QOF is osteoporosis. Around one in two women and one in five men over the age of 50 will suffer from a bone fracture during their lifetime, and over 300,000 patients present to hospital each year with fragility fractures. The cost to the NHS for treating hip fracture alone amounts to approximately £2bn per year.³⁵³

3.12 The human cost is also significant, with 80% of patients over 60 reporting that they would rather die than suffer the reduced quality of life that follows a hip fracture and transfer into social care³⁵⁴. Furthermore, around one third of hip fracture patients die prematurely within one year of suffering the fracture. In total there are approximately 3 million people in the UK either suffering from or at risk of osteoporosis, however the disease is currently not included in the list of QOF clinical indicators.

3.13 The absence of osteoporosis in the QOF means that, despite the high levels of prevalence, the disease is not currently being treated as a priority in primary care. Only a small minority of fracture patients have been tested for osteoporosis and are on treatment to maintain and increase their bone density. As a consequence, evidence from primary care studies have shown that among women with a past history of fracture only 5% had undergone a bone density scan and less than 10% were receiving treatment for secondary fracture prevention.³⁵⁵

3.14 Including a new clinical indicator linked to secondary prevention would incentivise GPs to refer patients who have suffered from a primary fragility fracture for a bone density scan and, if necessary, appropriate treatment. NICE has already recommended treatment for the secondary prevention of

³⁵³ Taken from the National Osteoporosis Society *Key Facts* briefing paper.

³⁵⁴ The Blue Book, British Geriatrics Society, British Orthopaedic Association, September 2007.

³⁵⁵ The Blue Book, British Geriatrics Society, British Orthopaedic Association, September 2007.

osteoporotic fracture in post-menopausal women.³⁵⁶ Increasing the number of osteoporosis sufferers on treatment would be a major step in reducing the large number of fractures treated by the NHS each year, so reducing a major health inequality which affects older people. Projections show that unless greater interventions are made in the care of osteoporosis patients, hip fracture rates and commensurate care costs will double by 2050.³⁵⁷

3.15 Inclusion of osteoporosis in the QOF is supported by the National Osteoporosis Society, the British Geriatrics Society, the British Orthopaedic Association, The Royal College of Nursing and the Faculty of Public Health. A recent report commissioned by The NHS Information Centre based on a new clinical audit of fragility fracture patients also called for osteoporosis to be included in the QOF.

The importance of early diagnosis and management

3.16 A major reason for health inequalities in conditions such as cancer is the later presentation and diagnosis of some groups within society. This can be attributed to lower levels of health literacy, poorer access to health services and lifestyle factors. Primary care services have a major role to play in addressing this, through:

- Encouraging uptake of screening
- Promoting greater awareness of signs, symptoms and risk factors
- Ensuring accessibility to appropriate advice and services
- Enabling GPs and other healthcare professionals to make prompt and accurate referrals for further investigation

3.17 We therefore welcome the announcement of the National Awareness and Early Detection Initiative for cancer. Although focused on one disease area, we believe that this initiative may well produce lessons for other disease areas and therefore should be followed closely.

3.18 Another example of the critical importance of early diagnosis is chronic kidney disease (CKD), where not only can early identification arrest disease progression, but can prevent costly “crash landing” into dialysis, which is associated with unnecessarily high mortality. CKD has recently been included in the QOF and early feedback suggests that rates of early identification have increased.

4. THE EFFECTIVENESS OF PUBLIC HEALTH SERVICES AT REDUCING INEQUALITIES

4.1 Reducing health inequalities should be a core function for public health services. However, there is some evidence that, when subject to financial pressures, PCTs have deprioritised longer term public health programmes in favour of achieving financial targets. One such example is obesity, where a range of interventions have been cut in some health economies, despite the increasing profile and prevalence of the condition.

4.2 If implemented correctly, public health services can have a disproportionately beneficial long term effect on health inequalities. However, if a longer strategic approach is not taken, then there can be significant missed opportunities. An example of this is the diagnosis and treatment of hepatitis C. When diagnosed early, this condition can be effectively treated and cured. However, only a small proportion of the estimated patient population has been diagnosed and even fewer have been treated, meaning that England faces a potential public health time bomb.

4.3 Although England has a Hepatitis C Action Plan which sets out the framework for planning and delivering services, including earlier diagnosis, evidence collected by the Hepatitis C Trust suggests that very few PCTs are implementing the Plan.³⁵⁸ Few incentives or performance management mechanisms exist to ensure implementation and the time may now be right to revisit and revise the Plan in order to promote better implementation. We would welcome a recommendation from the Committee that the Department of Health should adopt a similar approach to that for cancer in developing strategies for less high profile conditions.

January 2008

³⁵⁶ NICE Technology Appraisal 87 (currently being reviewed on appeal).

³⁵⁷ The Blue Book, British Geriatrics Society, British Orthopaedic Association, September 2007.

³⁵⁸ The All Party Parliamentary Hepatology Group, A Matter of Chance, An Audit of Hepatitis C Healthcare in England, 2006 <http://www.hepctrust.org.uk/NR/rdonlyres/92D12999-0D64-4028-8E15-1931A7368B21/0/AMatterOfChancePCTAuditofHepatitisCHealthcare.pdf>

Memorandum by Bristol-Myers Squibb and sanofi-aventis (HI 47)

HEALTH INEQUALITIES

EXECUTIVE SUMMARY

- Despite welcome progress in tackling mortality from cardiovascular disease (CVD), inequalities persist in access to effective proven medicines across the country. These must be addressed.
- PCT's should adopt policies that seek to ensure that all patients who require treatment receive the right treatment for the right duration. In our experience some PCTs are using mechanisms such as incentive schemes and audits that focus on cost control and work against the pursuit of health inequalities.
- The Quality and Outcomes Framework (QoF) has been an effective mechanism for delivering change in GP clinical practice. However, conditions currently outside its scope, for example peripheral arterial disease (PAD)—a serious form of cardiovascular disease—may be less rigorously managed by comparison. The QoF needs to expand and evolve to keep pace with clinical knowledge and interventions.
- The Government has made good progress towards its targets for tackling CVD, but there is no room for complacency.

INTRODUCTION

1. Bristol-Myers Squibb and sanofi-aventis welcome the opportunity to respond to the Health Select Committee's inquiry into the contribution of the NHS in reducing health inequalities.

2. As the manufacturers of Plavix (clopidogrel), a leading branded anti-platelet therapy used in the treatment and secondary prevention of cardiovascular disease (CVD), we are committed to playing a constructive role in helping communities tackle health inequalities, which continue to persist in cardiovascular disease. We will be limiting our response to our experience in this area, and to the following points of focus:

- The extent to which the NHS can contribute to reducing health inequalities;
- The influence of GP services on health inequalities, including how the Quality and Outcomes Framework and Practice-based Commissioning might be used to reduce health inequalities; and
- Whether the Government is likely to meet its Public Services Agreement targets in respect of health inequalities.

3. Significant health inequalities are associated with CVD³⁵⁹. We therefore welcome this inquiry as an important opportunity to tackle health inequalities, particular in relation to CVD prevalence and outcomes.

THE EXTENT TO WHICH THE NHS CAN CONTRIBUTE TO REDUCING HEALTH INEQUALITIES

4. Cardiovascular disease (CVD) is the number one killer in the United Kingdom and has been identified as a key target for health improvement. The main forms of cardiovascular disease (CVD) are heart attack, stroke and peripheral arterial disease (PAD). CVD causes four out of every ten deaths in the UK.³⁶⁰ It is long term and life-threatening with a significant burden of care to the NHS.

5. The NHS has a key role to play in ensuring that health inequalities are reduced, not least because a reduction in the numbers of patients hospitalised with CVD morbidities would free up valuable NHS resource. There are many factors which contribute to health inequalities in CVD. Primary prevention strategies such as improving diet, exercise and reducing smoking rates are important if we are to succeed in reducing prevalence in the long term.

6. Advances in our knowledge of how to manage CVD also offer significant opportunities to reduce inequalities, both in terms of treatment and secondary prevention. Anti-platelets are one such intervention. Anti-platelets, such as Plavix or aspirin, are used to reduce the platelets forming a blood clot, reducing the risk of another heart attack or stroke occurring. They can be used alone, or in combination (in certain heart conditions). Anti-platelet therapies therefore have an important role to play in the immediate treatment of patients who have had a cardiovascular event, and in the secondary prevention of further events. Clear guidance from the National Institute for Health and Clinical Excellence (NICE) sets out the role that anti-platelets should play in managing CVD^{361, 362}.

³⁵⁹ Department of Health, *Health Profile of England 2007*. October 2007.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_079716

³⁶⁰ Office for National Statistics; General Register Office, Edinburgh; General Register Office, Northern Ireland.

³⁶¹ NICE Technology Appraisal TA080: *Clopidogrel in the treatment of non-ST-segment-elevation acute coronary syndrome*. July 2004. <http://www.nice.org.uk/page.aspx?o=TA80>

³⁶² NICE Technology Appraisal TA090: *Clopidogrel and dipyridamole for the prevention of atherosclerotic events*. May 2005. <http://www.nice.nhs.uk/guidance/TA90> (+ National Institute for Clinical Excellence clarification: Available at: <http://www.nice.org.uk/page.aspx?o=274726>)

7. However, we are concerned that inequalities remain in access to these proven therapies. Drawing on prescribing data from summer 2005 to 2006, unpublished research commissioned by our two companies demonstrated that despite the existence of national guidance on the use of anti-platelets, significant variations in prescribing remained. Overall there was more than a six-fold variation in the usage of anti-platelets between the highest and lowest prescribing PCTs. When “outriders” were removed (those in the 95th and 5th percentiles) a two-fold variation remained.

8. There were striking regional variations in usage of anti-platelets. Strategic Health Authorities (SHAs) do, of course, vary in terms of the health needs of the population they cover and it is right that they should tailor health services to reflect this. However people living in the South West were nearly twice as likely to be prescribed anti-platelets as Londoners. Likewise, there was a considerable variation in spend on coronary heart disease (CHD), with the South West spending more than 20% more on CHD than London. These inequalities could not be entirely explained by variations in CHD prevalence or deprivation.

9. Significant inequalities also exist in discharge practice. A national audit of 1400 patients with acute coronary syndromes during January–October 2005 found that the percentage of patients discharged on clopidogrel fell way below that recommended by NICE, with only 39–60% of eligible patients leaving hospital having commenced clopidogrel treatment.³⁶³

10. Some PCTs in England have in place incentive schemes to control the use of medicines or have conducted audits of the usage of particular medicines. It is important that NHS organisations seek to maximise value for money but very often these policies are driven by the need to reduce costs rather than ensure that the right patient gets the right medicine. Incentive schemes and audits focused primarily on cost-control risk compromising patient outcomes and safety, delivering a short term financial “fix” at the expense of failing to address the longer term underlying health needs of a population.

11. We believe that audits can be used effectively, but only when based on the following principles:

- a proper assessment of individual patient clinical need and ongoing risk;
- ensuring appropriate usage according to good practice evidence and national guidance; and
- the patient making an informed choice

12. Unless equitable and appropriate access is given to these interventions, then there is a risk that health inequalities could actually widen: the health literate and most articulate people in society will continue to demand the best healthcare, while more disadvantaged groups will go without.

THE INFLUENCE OF GP SERVICES ON HEALTH INEQUALITIES, AND THE USE OF THE QUALITY AND OUTCOMES FRAMEWORK AND PRACTICE-BASED COMMISSIONING TO REDUCE HEALTH INEQUALITIES

13. CVD patients are, increasingly, living with their disease and managing their condition over the long term. They therefore rely on primary care services to provide them with effective interventions and support. The Quality and Outcomes Framework (QoF) has been an effective mechanism for ensuring that GPs identify and register patients with conditions singled out in the clinical domains, offer appropriate interventions to manage these conditions and monitor ongoing disease management. We believe that improving clinical practice should remain the focus for QoF, rather than seeking to use it to address other policy priorities, such as improving out of hours GP provision.

14. If the potential of the QoF to improve clinical practice is to be maximised, it needs to evolve, continuously incentivising clinical excellence. We therefore believe that the QoF needs to be expanded and built upon, addressing new clinical areas and keeping pace with increasing clinical knowledge about effective interventions. Anomalies still exist in the QoF with regard to the diseases which are included and those which are not, and this can lead to less rigorous management of those outside its scope.

15. For example, CVD can present as a multivascular disease, taking three main forms—CHD, stroke and peripheral arterial disease (PAD)—but only CHD and stroke are acknowledged in the current QoF. PAD is a significant omission. Using European data, it can be estimated that there are at least 720,000 people with symptomatic PAD in the UK (6% of the over 60 UK population of 13m).³⁶⁴ Symptomatic PAD carries a 30% risk of death within five years, rising to almost 50% within 10 years, mainly due to heart attack (60%) and stroke (12%).³⁶⁵ Results of a multi-national registry show that PAD has a one-year cardiovascular risk (that is, a risk of cardiovascular death, stroke, heart attack or hospitalisation) which, at 18.2%, is significantly higher than that of CHD (13.3%).³⁶⁶

³⁶³ Innovex Health Management Solutions. *Audit of Clopidogrel Prescribing in Acute Coronary Syndromes (ACS)*. Unpublished, but available on request.

³⁶⁴ Norgren L, Hiatt WR et al. Inter-Society Consensus for the Management of Peripheral Arterial Disease (TASC II). *Eur J Vasc Surg* Vol 33, Supplement 1, 2007.

³⁶⁵ Tierney S, Fennessy F, Bouchier-Hayes D. Secondary prevention of peripheral vascular disease. *Br Med J* 2000; 320: 1262–5.

³⁶⁶ Steg PG, Bhatt DL, Wilson, PWF et al. Reduction of Atherothrombosis for Continued Health (REACH) Registry Results: 1-Year Cardiovascular Event Rates in a Global Contemporary Registry of over 68,000 outpatients with Atherothrombosis. *JACC* 2006;47(4):168A.

16. Despite this significant cardiovascular morbidity and mortality PAD is under-diagnosed and under-managed. If the Government is to reach its targets for Coronary Heart Disease (CHD) management in the UK, which forms one of its main health aspirations, PAD should be recognised as a significant health burden and managed with the same vigour as CHD. This should include an expansion or reallocation of clinical domain points to include the registration and management of symptomatic PAD.

17. We would welcome a recommendation from the Committee that NHS Employers and the British Medical Association, as the negotiators of the QoF, should prioritise reaching an early agreement on evolving those indicators included in the clinical domain, so incentivising further improvements in the management of conditions such as PAD, helping to tackle health inequalities.

WHETHER THE GOVERNMENT IS LIKELY TO MEET ITS PUBLIC SERVICE AGREEMENT TARGETS IN RESPECT OF HEALTH INEQUALITIES

18. Welcome progress has been made on tackling CVD. If this continues, the Government is on track to meet its two PSA targets relating to CVD:

- to reduce deaths from CHD, stroke and related diseases in people under 75 by at least two fifths by 2010
- to reduce the inequalities gap in premature death rates from CVD between the areas with the worst health and deprivation indicators and the rest of the population as a whole by 40%

19. Figures for England released by the Department of Health in September 2006 indicate that the death rates for people under 75 from CVD have reduced by 35.9% since 1996. This amounts to almost 150,000 lives being saved since 1996—a number similar to the entire population of Blackpool.³⁶⁷

20. However there is no room for complacency. Inequalities in CVD persist, and the target is for a narrowing of the gap rather than an eradication of it. We are keen to see that the welcome progress on CVD does not stop when the PSA deadlines are reached, and to work in partnership with the NHS and others to see that inequalities continue to reduce.

January 2008

Memorandum submitted by Unite (Amicus section) (HI 48)

This evidence to the House of Commons Health Select Committee is submitted by Unite (Amicus Section). Unite is the UK's largest trade union with 2 million members across the private and public sectors. The union's members work in a range of industries including manufacturing, financial services, print, media, construction, transport and local government, education, health and not for profit sectors.

Unite (Amicus section) is the third largest trade union in the National Health Service and represents approximately 100,000 health sector workers. This includes seven professional associations—the Community Practitioners and Health Visitors' Association (CPHVA), Guild of Healthcare Pharmacists (GHP), Medical Practitioners Union (MPU), Society of Sexual Health Advisors (SSHA), Hospital Physicists Association (HPA), College of Health care Chaplains (CHCC) and the Mental Health Nurses Association (MNHA)—and members in occupations such as allied health professions, health care science, family of psychology, counsellors and psychotherapists, the family of dental professions, audiology, optometrists, opticians and building trades, estates, craft and maintenance.

EXECUTIVE SUMMARY

- It is the view of this organisation that the NHS can make a significant contribution to reducing health inequalities, particularly thorough targeted support and early interventions for children and their families as delivered by health visitors in the home and school nurses in schools. However without a massive investment in these professions these effects cannot be felt.
- Unite-Amicus have highlighted below the contribution these professions could be making and outlines the further inputs required by government to ensure they are delivered.

³⁶⁷ Department of Health Press Release: Mortality rates from heart disease and cancer improve. 27 September 2006. Available at: <http://www.gnn.gov.uk/environment/fullDetail.asp?ReleaseID=229973&NewsAreaID=2&NavigatedFromDepartment=False>

OVERVIEW

1. After a period of record NHS investment over the last 10 years, it is a tragedy that whilst this money has had great impacts on improving hospital waiting lists and patient satisfaction ratings, it has not had enough impact on reducing health inequalities (Wanless, 2007). Unite-Amicus support the view of many that this is due to disinvestment in public health and particularly public health practice. Indeed over the past 15 or so years there has been a steady erosion of services which health visitors once offered. This has been compounded by:

- The loss of a specific training council in the early 90s,
- A removal of protection of this professional role in statute in 2001
- The introduction of grade mix into the delivery of a very complex role
- A subsequent reduction of skilled health visitors, which we know has contributed to a weakening of their contribution to reducing inequalities.

2. As the government has demonstrated (Cabinet Office, 2006) effective outcomes are related to the skills of the staff making the inputs when tackling inequalities. The Unite/CPHVA Annual Omnibus Survey (Durdle Davies, 2007), made clear that these changes had led to many health visitors often not having the resources to either identify or respond to the needs of many of their vulnerable clients (Craig & Adams, 2007 see Appendix 1).³⁶⁸ 32% of respondents reported they could no-longer respond to the needs of all their vulnerable clients. Further a survey by the Family and Parenting Institute showed that there is a postcode lottery of health visitor provision with the lowest caseload sizes not necessarily occurring in areas of greatest vulnerability (Gimson, 2007).

3. Currently we have the lowest number of health visitors employed for 13 years (The Information Centre, 2007) despite:

- A growing birth rate,
- Very high levels of immigrants, migrant workers and asylum seekers,
- An increasing number of children with complex needs,
- An increasing demand on their time from other agencies particularly social services.

Furthermore there have been:

- Reductions in health visitors trained by over 40% (Unite/CPHVA, 2007) for the past 2 years.
- Higher levels of stress amongst health visitors than most sections of the NHS workforce (NHS Employers, 2007). This was reinforced by Unite-Amicus' own survey where 75% of respondents (n = 1,000) reported they were aware of colleagues off with work related stress and 77% indicated an increase in their own work places stress during this period (Durdle Davies, 2007).

4. Unite-Amicus believe that many of the health issues currently requiring increasing investment by the government relate to this reduction in the universal health visiting service. For example, obesity, and mental health. This is probably particularly important in relation to the increases in children requiring secondary input for emotional and mental health issues. These issues are most closely related to the family environment experienced by the child.

5. The health visitor can have a very profound working with families and particularly when children are vulnerable to social disadvantage or there are significant inequalities. Unpublished Unite-Amicus research has demonstrated that the health visiting service can impact in many ways to promote mental health in families (Adams, 2006). In so doing a child's self esteem and emotional resilience grows and that child is more likely to be successful in school, in the workplace and in developing relationships throughout his or her life. In this way children can leave a situation of emotional stress behind and be less likely to develop mental illness and become a victim of inequality.

6. Despite misunderstanding by some in government health visitors have traditionally and continue to focus many of their efforts on supporting their most vulnerable clients and many have very well developed specialist skills to do so. In particular they target those who are victims of significant health inequalities such as the homeless, gypsies and travellers, prisoner's families and young mothers. See Appendix 2³⁶⁹ for details of how health visitors address the needs of some of these groups and in so doing address inequalities. (Unite/CPHVA, unpublished, 2008)

7. In 2007 the Department of Health published a review into the role of the health visitor (DH, 2007). Unite-Amicus completed a response to this document (Adams *et al*, 2007) and this has been included in Appendix 3 for the committee's information.³⁷⁰ Unite-Amicus are very concerned that unless the government moves very quickly to stem the loss of skilled health visitors the potential impact of their service on health inequalities will continue to diminish.

³⁶⁸ Not printed.

³⁶⁹ Not printed.

³⁷⁰ Not printed.

8. Unite-Amicus is equally concerned by the continuing low numbers of trained school nurses. Following specialist practice training school nurses are well equipped to support the most vulnerable school age children.

NHS CONTRIBUTION TO REDUCING HEALTH INEQUALITIES

9. As is demonstrated in *Every Child Matters; Change for Children* (DfES, 2006) health is a key aspect of any desire to reduce health inequalities, as is evident in the name itself. One of the advantages that the National Health Service has had previously is that of its acceptability of its services to those individuals and families that have historically had difficulty in accessing other services. In fact the advantage that every person in the country should be able to say they have a general practitioner, every ante-natal mother has a midwife and every new family has a health visitor should not be understated or underestimated. These professionals really understand communities and those who live in them. Through their universal access they are perfectly placed to assess need, identify vulnerability and activate other services to alleviate it by, for example, improving access to financial support or better housing. As Sure Start and family centres have found, accessing the most vulnerable children can be very difficult where there is not good support from health services and health led Sure Starts' have been found to produce the best outcomes for children (Barnes *et al*, 2005)

10. The ability of a child to embrace education is closely related to their degree of "happiness" or emotional health. The education system is most challenged where the children are most challenging. Early intervention to better support families so children enter education with sound cognitive development and emotional resilience is therefore logical. There is also no doubt that children benefit from access to two parents who love them. Many have to be helped to be able to demonstrate love to their children and to understand their social health needs. Health visitors will provide this support where they are properly resourced. There are also well researched health visitor interventions to support the inter-parental relationship which is usually key to a happy home (Simons *et al*, 2003)

11. A reverse question could be set regarding every other public service, agency and department that deals with any issue. For example, how can local authorities contribute to health inequalities, given that many of the causes of inequalities relate to other policy areas?

DISTRIBUTION AND QUALITY OF GP SERVICES

12. One of the key issues raised by Unite-Amicus members concerning General Practice services are that unlike the rest of children and young peoples services being more based around locality or geographically based, GP services are still provided via lists (where practices can decide whether to accept patients). This has the effect of creating confusion and difficulties regarding inter-agency and multi professional team working. Members report that as well as having to liaise with many agencies they also have to be linked to multiple GP practices; these often have many partners.

13. Care must be taken that GPs do not reject the most vulnerable as they are burdensome. Also, many very vulnerable people do not access GPs eg the homeless, travellers and asylum seekers. Systems need to be set up to improve access, we believe walk in centres have been helpful.

EFFECTIVENESS OF PUBLIC HEALTH SERVICES

14. This raises two issues in so far as are smoking and obesity an example of causes of health inequality? You can look at the inequality being that some people smoke and if they smoke then they are more likely to be unwell, or that there is a section of society that has poorer access and ability to remain healthy and they are more likely to be a smoker/obese due to stress or lack of access to healthy foods. This maybe highlights some of the problem with some public health services, in that the service is designed around smoking cessation. This will by its nature be more appealing to those people who know they want to give up, and therefore, does this support those in "higher" socio-economic groups. Those services that provide universal access will be able to uncover hidden vulnerability and ensure that inequalities are reduced by supporting client centred interventions. Someone who is unhappy and living in conditions of misery may smoke, drink or take drugs to help alleviate the stress. A holistic and client centred approach needs to be taken to help such individuals.

15. In general the most cost effective interventions for smoking and drinking are probably those which reduce access eg via taxation in general. However someone who is miserable may chose suicide as a way of coping if other "props" are not available. They are less likely to respond positively to "blanket" public health measures. Those with good emotional resilience are less likely to be substance abusers so early emotional support is worth investing in.

16. The question regarding public health interventions having the effect of increasing health inequalities, may be in fact true, in that a proportion of the population will have greater health benefits than others. What should not be ignored, in that a greater positive impact is a good outcome, but also a more minimal improvement is still an improvement.

An example from a Unite-Amicus member would be:

“When the new advice came out regarding delaying weaning babies onto solid foods until six months, people in higher socio-economic groups responded more quickly to the advice, but the lesser response from lower socio economic groups is still having a positive effect on their children’s health”.

17. This also raises the question about social marketing in that to make something attractive to a group of people you can’t just market it to the most socially excluded as they will see it as a stigmatised service.

18. An example of some of the problems experienced regarding the current “targeting” in health inequalities could be shown by the following example:

Unite/CPHVA has consulted with its school nurse members to find out how the DH’s National Child Measurement Programme guidance is working in practice, and how it could be used better to prevent and treat overweight children in primary school. The department’s target is that over 80% children will be measured, increasing year on year. The school nursing service varies tremendously with some areas employing health care assistants solely to do this work. In other areas school nurses are extremely hard pressed; we had examples where a school nurse and her colleague have a case load of 9,000 children. School nurses take their public health role seriously and are extremely frustrated that there are too few of them to carry out all the work which the various public health documents recommend in order to reduce health inequalities in children.

There is a general lack of belief that the data collected is an accurate reflection of the population. The nurses report that in every class, two or more children opt out from being weighed, and these are nearly always the overweight children. The nurses do not understand why a statistical sample of 11 years olds can’t be used for national data collection. There are ethical concerns around the fact that as the data is collected anonymously, the school nurse has no mechanism to follow up overweight children. The health service will know that the child’s BMI is too high, but the parents will not. Therefore the child is not helped by this system, and nor are the health inequalities issues dealt with.

IMPACT OF SPECIFIC INTERVENTIONS

19. One of the key issues raised by Unite-Amicus members regarding any initiative is the short term nature of any funding versus the desire to have long term outcomes and benefits. Members have contacted us with examples of issues raised with this approach. For example, a Unite-Amicus member reported that an regional area affected a massive reduction in the number of women smoking during the ante-natal period. This was achieved by a health visitor and midwife working together in a Sure Start centre in a team approach. When the Sure Start service was “mainstreamed” into the Children Centre, the midwife was “pulled” back into the acute service (returning to be hospital based) and the improvement in stop smoking was seen to reverse.

20. This experience of Unite-Amicus members appears to be supported in the document “Our Future Health Secured” (Wanless *et al*, 2007) in that “this [conceptual public health] framework was not taken forward and, as a result, health policy has remained focused on short-term imperatives, public health practitioners feel undervalued and significant opportunities have been lost”.

21. In some areas, Sure Start Local Programmes have attempted to ensure that black and minority ethnic populations are fully engaged. The report “Sure Start and Black and Minority Ethnic Populations, (Craig *et al*, 2007)” highlights the importance of health services being integrated into these services, “acknowledging the key role health visitors play in delivering the programme and praised staff for their success in creating links with BME parents who felt that social services had little understanding of cultural and traditional parenting practices” (Tweddell, 2007). However this cannot be a short term approach as to affect change in a population takes more time than 3–5 years.

22. An even more insidious outcome of the recent amalgamations of primary care trusts in England have been larger wholesale reductions in services where we have been provided with examples of services being cut. An example given by a Unite-Amicus member is the South East was that previously services had been developed to support women who have had a miscarriage. On the amalgamation of 2 trusts, the group leaders were asked to stop providing this well evaluated service as they couldn’t provide it to all areas in this new trust, so it had to stop (Adams *et al*, 2007). Unite-Amicus believe this is a perverse outcome, especially when the Government is pushing an agenda where they support services being provided to those families that require them.

23. A major problem since the financial cutbacks in public health community practice has been the subsequent loss of leadership and innovation. Unite-Amicus experience suggests that in response to intolerable working conditions many public health practice leaders have voted with their feet by taking early retirement or leaving the NHS. Innovation has been quashed by unrealistic caseloads and a lack of valuing of specialist services and professional expertise.

SUCCESS OF NHS ORGANISATIONS CO-ORDINATING ACTIVITIES

24. One of the key problems with the attempts of the NHS organisations to co-ordinate their activity is the large variation that presents itself across England (Triggle, 2007). When it is considered that in one strategic health authority they may have upwards of five different organisational structures that are intended to provide the same services, it can be seen how this causes problems. There may have structures where health staff are employed by either a PCT, the acute service, a mental health trust, a local authority, a childrens trust, a not for profit cooperative, a private limited company, a foundation trust etc (Amicus, 2005). This situation may become even more complex with future fragmentation of services being supported by policy. It is clear to Unite-Amicus that the losers are likely to be the most vulnerable.

EFFECTIVENESS OF THE DEPARTMENT OF HEALTH IN CO-ORDINATING POLICY

25. With the devolvement of decision making from the “national centre” to local decision makers, members have raised more frequent concerns regarding the decisions that are being made locally. An example would be with the decisions made around the number of staff employed. Which (2007) has highlighted several of the “postcode lotteries” regarding provision of service. One, that of the number of health visitors, directly impacts on Unite-Amicus members. Nationally the government has recently provided support to the role of health visiting and a call for more health visitors. This message is being ignored by some local PCT’s and their commissioners in favour of using less qualified staff, or by bringing in management consultants to reduce the service further (Harris, 2007 & Snow, 2007).

26. When challenged, PCT’s are repeatedly arguing that as they are not being instructed to improve this situation, then they use their resources to tackle those targets which face tougher sanctions if not met. More recently, Unite-Amicus and its members have had to lobby MP’s in London constituencies. In Enfield (Tarver, 2007) members have seen reductions in staff numbers (whilst having increasing numbers of families in the area) making the trust bottom in the “league table” for the number of health visitors to children. This is combined with having the highest rate of infant mortality in London. Sadly this is not related to just one area, and just in London in 2007, similar situations were challenged in Redbridge, Waltham Forrest and Hounslow. In fact if you look at the league table produced by the Family and Parenting Institute (Gimson, 2007) and compare that with the index of multiple deprivation rank for the area covered by each trust, you find that there is no correlation between deprivation and numbers of key health promotion staff (Appendix 4).

27. Another example of local areas “ignoring” national policy is that of school nurses. The Government, under the 2004 White Paper “Choosing Health” (Department of Health, 2004), allocated £42 million to PCT’s, children’s trusts and local authorities to provide at least one full-time, qualified school nurse to work with each cluster or group of primary schools. In “Children’s Health, Our Future” (Shribman, 2007) the number of school nurses was reported to have risen by 34%, but from Unite-Amicus figures, the target set will not be reached until 2023 at current training levels, with no school nurses leaving employment (Nursing Time, 2007). An example of this was Hounslow PCT who in September 2007 had none (Parish & Doult, 2007).

PUBLIC SERVICE AGREEMENTS

28. This seems unlikely unless a needs led, well trained health visiting service delivering interventions based on best evidence of effectiveness is supported much more robustly by government. To ensure public protection the role of the health visitor should once more be protected in statute as it was previously for almost 100 years. Furthermore the profession itself should be given more control to determine the shape of its training, health visiting leaders and specialists for vulnerable groups should be encouraged and supported and innovative practice valued. Over the past 15 years nursing had been very influential in the direction of health visiting, to its detriment as the role of the health visitor is a very different one based as it is on promoting health. To invest in health visiting and hence early intervention could produce massive savings to other areas of government expenditure related to inequalities in the longer term.

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January 2008

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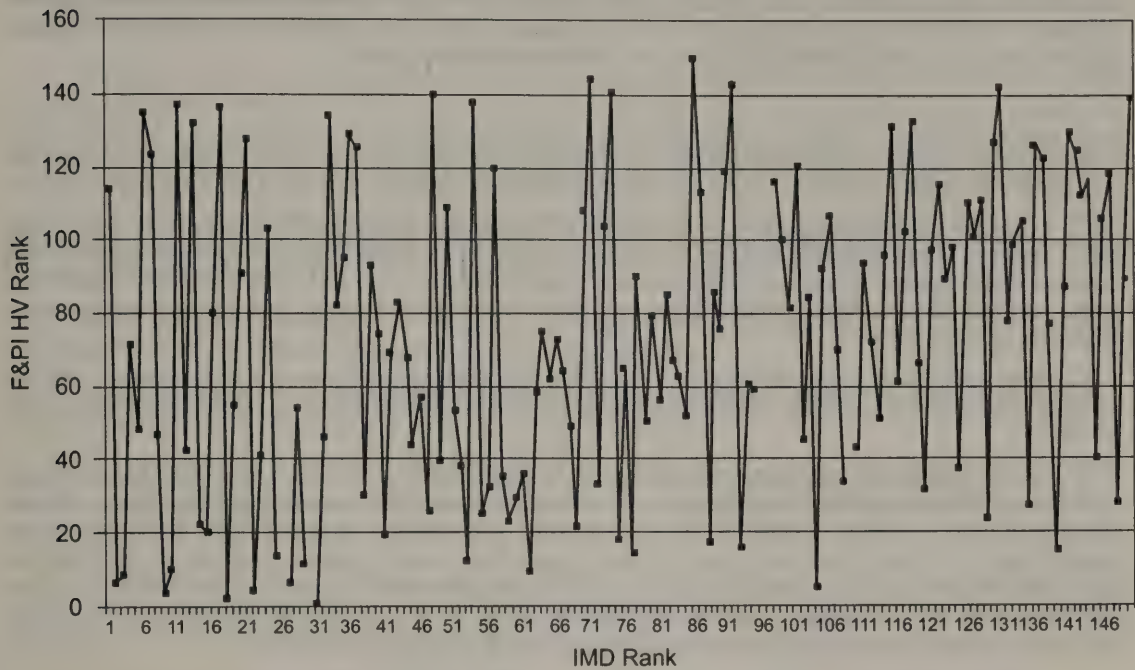
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Appendix 4—Index of Multiple Deprivation versus rank of Health Visitor numbers across England



Memorandum by the Foyer Federation (HI 49)

THE CONTRIBUTION OF THE NHS IN REDUCING HEALTH INEQUALITIES

EXECUTIVE SUMMARY

From the consultation with our members there is a clear message from Foyers that the NHS has an important role to play in tackling the health inequalities experienced by disadvantaged young people. Also, that the NHS has an important role in enabling organisations, like Foyers, to increase their impact on health through training, information and partnership working. NHS services are, in some instances, implementing effective initiatives in partnership with Foyers in particular outreach health services. However, the message is that NHS organisations need to reach out to the voluntary sector more, and be better resourced to undertake health improvement initiatives with disadvantaged groups and communities. Mental health is also a particular area that has had limited attention and investment in terms of health inequalities, and young people’s access to mental health services is a major concern reported by Foyers.

INTRODUCTION

1.1 The Foyer Federation develops and encourages new approaches to support young people as they make the transition to adulthood, particularly those who are at risk through homelessness, family breakdown or other factors. We work through a network of over 130 accredited Foyers providing holistic services to around 10,000 young people a year around the UK. At the heart of the Foyer approach is a formal commitment between the young person and the Foyer. For more than a decade, we have helped develop accredited learning programmes, initiatives in areas such as health and wellbeing and early intervention and quality assurance. Our campaigning and advocacy work draws directly on the experience of young people themselves.

1.2 The Foyer Federation is now attempting to apply the holistic Foyer approach more widely and develop new approaches that better meet the needs of those young people whose journey to adulthood is particularly difficult eg care leavers, young offenders and other vulnerable young people.

1.3 Foyers address the determinants of health insofar as they work with young people who are unstably housed, providing them with safe and secure accommodation while they undertake the transition to independent living. They also offer in-house training programmes in functional lifeskills and personal development, and refer young people on to external training provision and to employment.

1.4 The views expressed in this response are the outcome of consultation with our network. In this consultation response we respond to questions 1, 2, 3 and 5 of the key questions of the committee, but also discuss the specific issue of young people's access to mental health services and the particular health barriers faced by young people as identified in a survey conducted in Spring 2007.

The extent to which the NHS can contribute to reducing health inequalities, given that many of the causes of inequalities relate to other policy areas eg taxation, employment, housing, education and local government:

2.1 From our consultation response, it is clear that Foyers perceive other policy areas as such as ensuring stable housing, income and access to employment, education and training as having a greater impact on the health of disadvantaged young people than access to health services. Only 2 of the 23 responses argued that access to NHS services has a greater impact on health than stable housing, income and employment, education or training.

2.2 Moreover, the responses also made it clear that stable housing was a prerequisite for accessing health services. One Foyer stated that "Without stable housing it is difficult to access medical healthcare and advice".

2.3 The responses also highlighted the experience of successful work by NHS organisations to address health inequalities through improved targeting of services, outreach and developing services that are flexible and young people friendly. These initiatives were welcomed and seen as effective in increasing young people's access to health services. Overall, Foyers would like to see a greater emphasis by the NHS on prevention. Foyers argued that here is a need for "much more preventative and educational work" and that "We need more to offer young people in crisis. Better still we need more preventative services which will build self esteem, self confidence and educate people about looking after themselves".

2.4 A specific example of the latter comment is made by one Foyer: "In recent weeks we have had 4 separate occasions when we had to take a resident to A&E because of threats of suicide or actual self harm. While they all seemed to receive a reasonable service, they all needed intervention much earlier on".

2.5 Foyers were very positive about experiences of NHS staff providing training to them and workshops to young people to increase skills and knowledge for health improvement, but they noted that the availability of this was often lacking due to the stretched resources of health improvement staff in PCTs.

The distribution and quality of GP services and their influence on health inequalities, including how the Quality and Outcomes Framework and Practice-based Commissioning might be used to improve the quality and distribution of GP services to reduce health inequalities:

3.1 15 out of 23 Foyers who responded described the access that young people had to GP services as 'good' or 'excellent'. Positive experiences included GPs who were understanding of young people, co-operative and had built positive relationships with the Foyer. Less positive experiences included those where doctors have been dismissive, rude and inconsistent with young people (a specific example was around management of pregnancy). One Foyer mentioned difficulties with access to specialist referrals and also difficulties were noted with access GPs due to unhelpful appointment systems.

The effectiveness of public health services at reducing inequalities by targeting key causes such as smoking and obesity, including whether some public health interventions may lead to increases in health inequalities; and which interventions are most cost-effective:

4.1 Where public health services have targeted Foyer residents as a priority group, these initiatives are reported as effective in increasing young people's access to preventative services and health care. A common example given was sexual health services, which have targeted disadvantaged young people as part of Teenage Pregnancy strategies and funding. A significant number of Foyers are access points for condom distribution schemes, Chlamydia screening and outreach sexual health services. Examples of this include:

4.2 "We work with sexual health services in the Foyer and they are generally very good, with good access for young people"

4.3 "We have regular visits from the Sexual health team. The sexual health nurse visits the Foyer once a month".

4.4 "Training is provided by the NHS for staff in the Foyer for issuing condoms and giving sexual health advice. This allows staff to distribute condoms outside office hours".

4.5 It is notable the reported difference that the investment and targeting of sexual health services has made in improving access to sexual health services for young people. In our survey 15 out of 23 Foyers responding stated that young people's access to sexual health services locally was 'excellent' or 'good'. By comparison, 15 out of 23 Foyers said that young people's access to mental health services was 'fair' or 'poor'.

The success of NHS organisations at co-ordinating activities with other organisations, for example local authorities, education and housing providers, to tackle inequalities; and what incentives can be provided to ensure these organisations improve care:

5.1 Partnership working, outreach health services and capacity building in the voluntary sector through information and training were the key mechanisms used by the NHS to address health inequalities experienced by Foyers. Foyers consistently highlighted the importance and value of partnership working with health services in order to meet the needs and improve the health of disadvantaged young people. However, it appears that the quality of the partnership relationships can be hit and miss, with some very good experiences and some very poor or non-existent. Even within the same locality, a Foyer may have excellent relationships with an outreach nurse who runs a clinic in the Foyer, but find it impossible to engage with mental health services.

5.2 18 out of 23 Foyers said that the success of their local NHS organisations in working in partnership with them was 'fair' or 'poor'. Foyers cite the following examples:

5.3 "Can't even get a representative to sit on our sub-committee. Some pockets of good relationships—Health Visitors and Young Parent project staff work well together".

5.4 "Some links have been developed with both PCT and NHS services—but these are often initiated by the Foyer. When advice is sought both services can be accommodating but there need to be more strategic partnerships—which have a lasting effect on the quality of services offered and accessed by our residents".

5.5 "We have established some good links in the past but we have to work extremely hard to keep the relationship going. This in part due to lack of resources in the NHS and also due to constantly shifting staff meaning it is difficult to maintain relationships".

5.6 "I know there is the potential to do more".

Issues of access to mental health services for vulnerable young people:

6.1 As noted above 15 out of 23 Foyers said that young people's access to mental health services was 'fair' or 'poor'. The majority of comments about poor access to services concerned mental health services. Foyers gave the following examples:

6.2 "Approximately 78% of our residents have mental health issues. These young people are currently facing waiting lists of up to 18 months".

6.3 "Long waiting list and very limited access".

6.4 "There does not seem to be the same targeting that there is for general health".

6.5 In addition, Foyers commented that there seemed to be less alternatives to medication offered for mental health issues. One Foyer commented that "Access to sport and physical activities as alternatives to antidepressant medication seem to be geared to the older adult".

6.6 Given the high rates of mental health problems amongst the Foyer population, there does appear to be a need to target initiatives to tackle health inequalities in mental health.

Barriers to Health identified by Foyers and Young People:

6.7 In Spring 2007 the Foyer Federation conducted a consultation with Foyers and young people as part of a (successful bid) to the Big Lottery Well-being Fund.

6.8 The following tables list the responses given by Foyers when asked what the major gaps in health services for young people were:

<i>Top 8 gaps in services</i>	<i>% response</i>
Lack of a local/affordable gym	40%
Access to appropriate mental health service	19%
Support for lesbian, gay, bi sexual, transgendered young people	13%
Counselling	13%
Funding	9%
Lack of access to outside services due to location	5%
Lack of access to professional agencies due to waiting lists	5%

6.9 The following tables list the responses given by Foyers when asked what the major barriers to accessing health services for young people were:

<i>Top 8 barriers for young people</i>	<i>% response</i>
Cost of travel, cost of membership of GYM	48%
Confidence	27%
Stigma	20%
Travel	18%
Waiting lists	16%
Being judged	10%
Difficulties associated with being in a rural location	8%
GP and dentist closed lists	7%

6.10 As part of the survey young people were asked: "If you were given a budget to spend on a health and wellbeing project, how would you spend it?" Residents responded with the following (most popular first):

- Bring in chef to do cooking lessons;
- Bring in chef to do weekly dinner on Sunday so you eat well for at least 1 meal and you learn to cook too;
- Mental health nurse to come into Foyer;
- Using residents to teach other residents cooking skills;
- More interesting cooking lessons, tests on hygiene etc;
- Make fruit and vegetables available for free/cheap to residents;
- Free membership to gym;
- More sports equipment available at Foyer;
- More sports activities with prizes, incentives;
- Training regarding Spa (beauty and health) treatments.

Recommendations for action:

7.1 Increased investment in health improvement initiatives that target disadvantaged young people as a priority group eg through outreach and flexible services, in partnership with voluntary organisations and youth services.

7.2 A higher priority given to partnership working with the voluntary sector in order to address the needs of disadvantaged groups and communities.

7.3 A higher priority given to health improvement, prevention and early intervention in all areas of the NHS, especially mental health.

7.4 A review of the access to mental health services for young people aged 16–25.

January 2008

Memorandum by the British Lung Foundation (HI 50)

HEALTH INEQUALITIES

INTRODUCTION

1. Together with cancer and circulatory diseases, respiratory disease is one of the three greatest diseases of inequality in the UK. This submission from the British Lung Foundation focuses on the extent to which the NHS can help to achieve a reduction in health inequalities associated with respiratory disease, through primary and public health services.

³⁷¹ *Burden of Lung Disease*, British Thoracic Society 2006.

³⁷² *Ibid.*

³⁷³ *Ibid.*

EXECUTIVE SUMMARY

2. Respiratory disease is the UK's second biggest killer³⁷⁴ and the most common cause of emergency hospital admissions³⁷⁵. Almost half of all respiratory disease deaths (44%) in the UK are associated with social class inequalities.³⁷⁶
3. Incidence and mortality rates from respiratory disease are higher in deprived populations due to: low birth weights; childhood chest illnesses; damp housing conditions; poor diet; smoking; and dusty occupations such as mining and milling.
4. Respiratory diseases associated with social class inequalities include lung cancer, COPD (Chronic Obstructive Pulmonary Disease), asthma, TB and childhood respiratory illnesses.
5. Deprived populations have the highest prevalence and highest under-diagnosis of COPD, a progressive lung disease caused mainly by smoking.³⁷⁷
6. The prevalence of smoking has declined greatly over thirty years but has remained over 60% in the poorest groups, despite changes in policy and social climate.³⁷⁸ Current evidence suggests that smoking cessation services are not reaching all sectors of society.³⁷⁹
7. A general lack of public awareness of COPD means that there are an estimated 2.8 million people in the UK who don't know they have the disease. If left untreated, it could severely restrict their lives and eventually kill them.³⁸⁰
8. Misdiagnosis of COPD is a common theme in the UK, as are repeated admissions to hospital and poor outcomes of care. On average 15% of those admitted to hospital die within three months.³⁸¹
9. Action on diagnosis, treatment and care of COPD would make a great difference to the delivery of the PSA target on health inequalities.
10. Research by the British Lung Foundation identifies communities at highest risk of future COPD hospital admission at postcode level and facilitates the precise targeting of at risk groups with social marketing campaigns. Many of these communities are in Spearhead areas.³⁸²
11. The BLF recommends the actions on pages 4–6 below. They include the following:
12. Existing QOF points in relation to spirometry testing should be linked to levels of spirometry training, ensuring that QOF points are attributed to GP practices who guarantee that testing is carried out by appropriately trained individuals.
13. Existing registers of people with COPD in primary care should be developed to include stages of disease progression, current treatment plans and whether end of life care is needed. Existing QOF points in relation to the register should be amended to reflect this change.
14. Smoking cessation services and nicotine replacement therapy should be made available for as long as is needed and delivered in a non-judgmental manner.
15. Each PCT should ensure that one of the 6 awareness campaigns it is obliged to carry out every year should be a respiratory disease campaign. Targeted awareness and diagnosis campaigns should be undertaken, particularly in the most deprived communities in the UK, to find people with undiagnosed COPD and ensure they receive appropriate treatment and care.
16. A written information pack should be given to all those diagnosed with COPD. New QOF points should be introduced for delivery of such information.
17. The tariffs for Acute Care should be unbundled so that community care for people with COPD can be funded and unnecessary hospital admission avoided.
18. PCOs should identify those at risk of COPD in the community and introduce services aimed at preventing unnecessary hospital admissions (outlined below).

³⁷⁴ *Burden of Lung Disease*, British Thoracic Society 2006.

³⁷⁵ *Ibid.*

³⁷⁶ *Ibid.*

³⁷⁷ Association of Public Health Observatories.

³⁷⁸ GHS 1973 and 2004.

³⁷⁹ Northwest Public Health Observatory.

³⁸⁰ Shahab L, Jarvis MJ, Britton J, and West R, Prevalence, diagnosis and relation to tobacco dependence of chronic obstructive pulmonary disease in a nationally representative population sample.

³⁸¹ Commission for Healthcare Audit and Inspection, *Clearing the Air: A national study of chronic obstructive pulmonary disease*, 2006.

³⁸² *Invisible Lives: Chronic Obstructive Pulmonary Disease (COPD)—finding the missing millions*. British Lung Foundation, 2007.

BACKGROUND

19. Respiratory disease is the second biggest killer in the UK, accounting for 117,456 deaths a year. It is the most common cause of emergency hospital admissions and costs the NHS and society as a whole £6.6 billion a year.³⁸³

20. Almost half of all respiratory disease deaths (44%) in the UK are associated with social class inequalities compared with 28% of deaths from ischaemic heart disease.³⁸⁴

21. Respiratory diseases associated with social class inequalities include lung cancer, COPD, asthma, TB and childhood respiratory illnesses. The issue of lung cancer is being addressed by the Department of Health under the Cancer Plan and the Cancer Reform Strategy.

22. COPD (Chronic Obstructive Pulmonary Disease) is a progressive lung disease caused mainly by smoking. Deprived populations have the highest prevalence and highest under-diagnosis of COPD.³⁸⁵

23. COPD “hotspots” are concentrated in Scotland, ex-industrial and inner city areas of Northern England, and pockets of deprivation in otherwise affluent areas. Many of these hotspots have been identified as Spearhead areas.³⁸⁶

24. In women, respiratory disease accounts for 21% of the life expectancy gap between Spearhead areas and the rest of England—only circulatory diseases account for more (30%). COPD accounts for more than half of the respiratory total.³⁸⁷

25. In men, respiratory disease accounts for 15% of the life expectancy gap between Spearhead areas and the rest of England—only circulatory diseases and cancers account for more. COPD accounts for more than half of the respiratory total.³⁸⁸

ISSUES CONCERNING HEALTH INEQUALITIES ASSOCIATED WITH RESPIRATORY DISEASE.

26. Social class and poverty have an important effect on determining who has respiratory disease and who dies from it.

27. Incidence and mortality rates from respiratory disease are higher in poorer social groups due to:

- (a) Antenatal and early life experiences: low birth weights; childhood chest illnesses; poor housing where families are exposed to damp and mould; poor diet; obesity; exposure to second hand smoke
- (b) Occupation—respiratory diseases such as COPD are high amongst occupations such as coalmining and other dusty jobs. The UK is about to experience an epidemic of the chest cancer mesothelioma, which occurs amongst those exposed to asbestos in the workplace.
- (c) Smoking—just under half of respiratory diseases are caused by smoking. The prevalence of smoking has declined greatly over thirty years but has remained over 60% in the poorest groups, despite changes in policy and social climate. Poorer smokers are much less likely to have quit and take in substantially more nicotine from their smoking and are more dependent.

28. At present about 24% of adults, or 10 million people, are smokers. At current reduction rates, it will take around 20 years to reduce this figure to 5 million. Half of this number will die prematurely from smoking, and social inequalities in mortality are likely to become more pronounced. Current evidence suggests that smoking cessation services are not reaching all sectors of society.

29. Communities in greatest need are least likely to receive the health services that they require. The diagnosis and treatment of lung disease has been neglected by local and national health care services in the UK, partly because of its association with smoking and partly through a lack of awareness amongst the public and health care professionals, particularly in primary care, of diseases like COPD.³⁸⁹

30. Misdiagnosis of COPD is a common theme, as is repeated admission to hospital and poor outcomes of care. On average 15% of those admitted to hospital die within three months.³⁹⁰

31. A general lack of public awareness of COPD in particular means that there are an estimated 2.8 million people³⁹¹ with the condition who don't know they have a disease which, if left untreated, could severely restrict their lives and eventually kill them. Most people are currently diagnosed when the disease is in its later stages when symptoms are severe and extensive lung damage is not reversible.³⁹²

³⁸³ *Burden of Lung Disease*, British Thoracic Society 2006.

³⁸⁴ *Ibid.*

³⁸⁵ Association of Public Health Observatories.

³⁸⁶ *Invisible Lives: Chronic Obstructive Pulmonary Disease (COPD)—finding the missing millions*. British Lung Foundation, 2007.

³⁸⁷ Association of Public Health Observatories.

³⁸⁸ *Ibid.*

³⁸⁹ Commission for Healthcare Audit and Inspection, *Clearing the Air: A national study of chronic obstructive pulmonary disease*, 2006.

³⁹⁰ *Ibid.*

³⁹¹ Shahab L, Jarvis MJ, Britton J, and West R, Prevalence, diagnosis and relation to tobacco dependence of chronic obstructive pulmonary disease in a nationally representative population sample.

³⁹² *Invisible Lives: Chronic Obstructive Pulmonary Disease (COPD)—finding the missing millions*. British Lung Foundation, 2007.

32. Research by the British Lung Foundation carried out by Dr Foster Intelligence shows that most of the “missing millions” of people with COPD are likely to be found in the most deprived communities in the UK. The research predicted COPD future hospital admissions in every PCO in the UK using various data sources including hospital admissions data; GP surgery registrations data; Experian’s Mosaic lifestyle segmentation and TGI Target Group Index Analysis. The research identifies communities at highest risk of COPD hospital admission at postcode level and facilitates the precise targeting of at risk groups with social marketing campaigns.³⁹³

33. Equity of provision is likely to widen health inequalities from COPD.

34. The government is unlikely to meet its PSA target in respect of health inequalities unless it addresses the above points. Action on the diagnosis, treatment and care of COPD would make a great difference to the delivery of this target.

35. BLF specialist respiratory nurses in Glasgow have made significant progress in providing treatment and care in the community of people with COPD, improving their quality of life and in reducing unnecessary hospital admissions.

THE BLF RECOMMENDS THE FOLLOWING COURSES OF ACTION FOR THE NHS TO REDUCE HEALTH INEQUALITIES IN RELATION TO RESPIRATORY DISEASE:

36. Ensure health professionals, particularly in primary care, receive better education and training in the causes and symptoms of respiratory disease.

37. Ensure health professionals in primary care have the skills and equipment to carry out regular and efficient spirometry testing (a simple lung test) on every individual from the age of 7 onwards, to be repeated every ten years or more often for those at increased risk of respiratory disease.

38. Care should be provided according to need, with the aim of achieving equity of outcome across different groups and areas.

39. Existing QOF points in relation to spirometry testing should be linked to levels of spirometry training, ensuring that QOFs are only paid to GP practices which can prove that testing is carried out by appropriately trained individuals.

40. Existing registers of people with COPD in primary care should be developed to include stages of disease progression, current treatment plans and whether end of life care is needed. Existing QOF points in relation to the register should be amended to reflect this change.

41. Smoking cessation services should be improved by extending the follow up time to one year and by making nicotine replacement therapy available for as long as it is needed.

42. Each PCT should ensure that one of the 6 awareness campaigns it is obliged to carry out every year should be a respiratory disease campaign. Targeted awareness and diagnosis campaigns should be undertaken, particularly in the most deprived communities in the UK, to find people with undiagnosed COPD and ensure they receive appropriate treatment and care.

43. An information pack should be given to all those diagnosed with COPD. The pack should be given on diagnosis and should be relevant to the stage of the disease. It should contain high quality information in a format and at a level of complexity appropriate to their needs and be culturally appropriate. It should include information about treatments such as Non-invasive ventilation.

44. New QOF points should be introduced for the production and delivery of such information.

45. Everyone with COPD should be given a self-management plan. This, together with the information above, should help people to manage their own condition better and to enable them to stay out of hospital, reducing the burden and cost of emergency admissions.

46. Written Care Plans should be introduced for everyone with COPD, including self-management plans for each patient.

47. Managed Clinical Networks for COPD should be established.

48. Non-invasive ventilation should be available for people with COPD who want it and are admitted to hospital.

49. People with COPD tell us they prefer to be treated at home. At present most payments contribute to keeping people with COPD in hospital. The tariffs for Acute Care should be unbundled so that community care for people with COPD can be funded.

50. Early supportive discharge should be available to everyone admitted to hospital with COPD and best practice followed on the provision of support at home.

51. PCOs should identify those at risk of COPD in the community and introduce services aimed at preventing unnecessary hospital admissions. These services could include:

³⁹³ *Ibid.*

52. Specialist help, advice and interventions should be available 24 hours a day for people with COPD who experience acute breathing problems. Patients prefer to receive this advice by telephone; a 24/7 Helpline and Advice service should be introduced to prevent unnecessary hospital admissions and help medication management.

53. Community nurses skilled in the care of people with COPD should be increased, particularly in areas of greatest need, following the good practice examples set by BLF nurses in certain areas of the UK.

54. Pulmonary rehabilitation should be provided for everyone with COPD who needs it according to existing NICE guidance, and follow up exercise classes should be provided for everyone who could benefit from it throughout the UK.

55. Patients and carers affected by COPD should be notified when they have reached the stage where end of life care is needed. A different package of care should be identified of a standard equivalent to that currently received by people affected by cancer.

56. The forthcoming NSF in COPD should be funded and taken forward in a positive manner.

57. A Health Equity Audit should be undertaken with regard to COPD incidence, prevalence and mortality.

58. Managed Clinical Networks for COPD in Scotland are an important first step but they must operate to the standard set by the forthcoming NSF for COPD as the incidence in Scotland is extremely high.

59. Respiratory strategies have been introduced in Wales and Northern Ireland but no action has been taken to implement them. These strategies must follow the examples set by England and Scotland in improving diagnosis, treatment and care for people with COPD.

ABOUT THE BLF

60. The British Lung Foundation (BLF) is the only charity working to help the eight million people in the UK with all lung conditions.

61. The BLF runs a network of support groups across the country for people living with lung disease. There are more than 200 Breathe Easy Groups across the UK, all run by patients to support patients.

62. The BLF provides a wide range of information on more than 40 lung conditions, in the form of leaflets and fact sheets, all of which can be accessed via our website (www.lunguk.org).

63. The BLF also funds medical research into all forms of lung diseases.

January 2008

Memorandum by Mencap (HI 51)

THE CONTRIBUTION OF THE NHS TO REDUCING HEALTH INEQUALITIES

Mencap is the UK's leading learning disability charity, working with people with a learning disability, their families and carers. We believe people with a learning disability should have choice, opportunity and respect with the support that they need.

Mencap welcomes the opportunity to respond to this inquiry. Our response will concentrate on the health inequalities facing people with a learning disability, and show how responses to health inequalities are once again leaving this group of people behind.

1. THE HEALTH INEQUALITIES OF PEOPLE WITH A LEARNING DISABILITY:

People with a learning disability face specific health inequalities, as highlighted in Mencap's 2007 *Death by indifference report*, and the Disability Rights Commission's 2006 report *Closing the gap*.

- The Disability Rights Commission report showed "people with learning disabilities die younger than other citizens. They also have high rates of unmet health needs"³⁹⁴. They highlighted a "fatal complacency" in the NHS that people with a learning disability "just do die younger".
- People with a learning disability are 58 times more likely than others to die before the age of 50.³⁹⁵
- Overall mortality among people with a learning disability is three times that of the general population (even with external causes of death taken into consideration).³⁹⁶

³⁹⁴ http://www.drc-gb.org/Docs/mainreportword_healthfil.doc

³⁹⁵ DRC, *Background evidence for the DRC's formal investigation into health inequalities*, 2006.

³⁹⁶ Tyrer F; Smith L K; McGrother C W, *Mortality in Adults with Moderate to Profound Intellectual Disability: A Population-based Survey*, Journal of Intellectual Disability Research, 51, 7, 520–527 (July 2007).

- In people with a learning disability aged 20–29 years, mortality was nine times higher in men, and 17 times higher in women.³⁹⁷
- Mencap's 2004 *Treat me right* campaign showed 70% of GPs had received no training to help them treat people with a learning disability and 90% felt that a patient's learning disability made it more difficult to make a diagnosis.

People with a learning disability are less likely to receive screenings, suffer poorer health, and health services struggle to meet the needs of this client group.

These inequalities are not related to geography, but to this particular group of people.

2. THE FAILURE OF EXISTING SCHEMES TO TACKLE THE HEALTH INEQUALITIES OF PEOPLE WITH A LEARNING DISABILITY:³⁹⁸

The types of health needs common in the general population differ from those most commonly experienced by people with a learning disability, and some health needs are specific to people with a learning disability.

Health initiatives in the mainstream try to tackle lifestyle related causes of death like ischemic heart disease, certain types of cancer and stroke. These are not the lead causes of death for people with a learning disability.

People with a learning disability are more likely to die from:

- Respiratory disease eg pneumonia and aspiration pneumonia
- Congenital cardio vascular disease
- Stomach, oesophageal and gall bladder cancers

They are more likely to suffer from:

- Constipation
- Reflux disorder
- Epilepsy
- Osteoporosis
- Hyperthyroidism (especially people with Down's syndrome)

Current public health initiatives to tackle inequalities which focus on geographical or social deprivation will not only fail to close the gap for people with a learning disability, but may increase it.

Tackling the health inequalities of people with a learning disability is not just about extending current programmes to include them, but developing new initiatives that tackle the specific needs of this group to produce equal outcomes

The government will not meet its legal obligations under the disability equality duty unless it takes action to promote equality in healthcare for people with a learning disability.

3. POSSIBLE ACTIONS:

To tackle these inequalities, action needs to be taken that specifically meets the needs of people with a learning disability.

One targeted action that appears to be having an impact on health inequalities for this group is annual health checks.

Evidence from annual health checks introduced in Wales reveals that 51% of those with a learning disability who received a health check had newly identified health needs. 9% had a serious health problem. Subsequent checks a year later identified further new health needs among 68% of people, and serious problems were identified in 11%. These figures highlight the need for health checks to take place at least once a year.³⁹⁹

³⁹⁷ *Ibid.*

³⁹⁸ Cooper, S-A., Melville, C., Morrison, J. (2004) People with intellectual disabilities. Their health needs differ and need to be recognised and met. *British Medical Journal*, 329, 414–415.

³⁹⁹ DRC, http://www.drc-gb.org/about_us/drc_wales/newsroom/news/investigation_exposes_healthca.aspx (November 2006).

4. CONCLUSION:

The health inequalities agenda clearly relates to people with a learning disability, but attempts to address these inequalities have largely missed this group. If attempts are not made, in line with disability discrimination law, to address their specific needs then current initiatives will once again leave people with a learning disability behind, and prevent them from having the healthy lives that give them the best opportunity to be full and active citizens in their communities.

January 2008

Memorandum by the Football Foundation (HI 52)

HEALTH INEQUALITIES

1. INTRODUCTION

The Football Foundation is the UK's largest sports charity, financially supporting a wide range of community projects. We are funded by the Premier League, The Football Association and the Government, who provide a total of almost £40 million a year.

Our mission is to improve facilities, create opportunities and build communities by:

- Putting in place a new generation of modern sports facilities in parks, local leagues and schools
- Providing capital/revenue support to increase participation in grass roots football
- Strengthening the links between football and the community, to harness the game's potential as a force for good in society, promoting health, education and social inclusion

Since 2000, we have funded over 4,000 projects worth more than £500 million and secured over £280 million in additional inward investment in sports facilities.

We believe that the causes of health inequalities are multi-faceted, including deprivation, literacy, crime and the built environment in which people live. We believe that football can play an integral role in addressing each of these causes, as well as encouraging people to lead healthier lifestyles. We therefore welcome the opportunity to contribute to this inquiry.

2. THE EFFECTIVENESS OF PUBLIC HEALTH INTERVENTIONS

As well as running a very successfully facility programme, the Football Foundation also funds projects which contribute to redressing health inequalities such as obesity and smoking.

There is evidence to support the use of football-related interventions, which can appeal to groups in society who may not be engaged with traditional health services. Examples of the projects we currently support include:

- Middlesbrough FC's "Fit through Football" project (Foundation Grant: £148,920)—in one year 2,318 pupils at 56 local schools took part and a further 481 took part at after-school clubs. The key messages delivered were: diet and exercise, promotion of sport, anti smoking/drugs. Participants demonstrated a 40% average increase in the practise of healthy lifestyle issues.
- Northumberland smoke-free soccer (Foundation Grant: £3,080)—20% of 14 year olds smoke in Northumberland which is above the national average. Smoke Free Soccer takes places over ten-weeks and consists of hour-long sessions of football and informal smoking education. It reaches over 600 children aged 4–17 (mostly girls), many from rural and isolated parts of North Northumberland. 48% of girls who had previously not exercised now participate regularly.
- Federation of Stadium Communities with Port Vale FC and MEND (Foundation Grant: £123,134)—the programme runs for 10 weeks, involving one hour per week of physical activity (football or swimming) and one hour per week of health awareness workshops.

We believe that there is much more that can be done to harness the unique appeal of football to engage people in health issues. By targeting these interventions at groups in society with particularly poor health outcomes, football can play a significant role in reducing health inequalities.

We therefore welcome the commitment by the Department of Health in the recent Cancer Reform Strategy to work in partnership with the Foundation to pilot innovative approaches using football to raise awareness about the signs and symptoms of cancer, as well as prevention.

3. THE SUCCESS OF THE NHS ORGANISATIONS AT CO-ORDINATING ACTIVITIES WITH OTHER ORGANISATIONS TO TACKLE INEQUALITIES

There are good examples of joint working between the NHS and other organisations, such as:

- Manchester City FC City in the Community—Getting Manchester Moving (Foundation grant: £205,080)—a city-wide campaign that promotes and raises awareness of physical activity, its benefits and where these activities can be accessed. It has a particular focus on weight management and obesity. The strong partnership between City in the Community, Manchester City Council and Manchester PCT was formed in an attempt to address some of the critical health issues affecting the population of the city and has a wide reach due to a number of activities being run at Manchester City FC's stadium and/or using the hook of football to attract participants.

However, much more can be done in this respect. The Government's "Football and Health" document, which we played an integral part in producing, set out how PCTs could work with football organisations to deliver innovative interventions, but unfortunately too few have acted on this advice and therefore the true potential of football as an agent for better health has yet to be realised. Feedback from community groups as part of the Foundation's grant application process suggests that they would like to work more closely with PCTs, but find it difficult to identify the most appropriate person with whom to engage.

4. RECOMMENDATIONS

We would welcome consideration by the Committee of the following recommendations:

- The Department of Health's commitment to work with the Football Foundation to test innovative approaches to improving the awareness and early detection of cancer is to be commended and, if successful, should be extended to other disease areas.
- The Department of Health's "Football and Health" document should be re-publicised and PCTs should be encouraged to consider how best to work with football organisations as part of their strategic planning process.
- PCTs should be required to publicly identify a point of contact for community sports groups to engage with, promoting greater opportunities for joint work to tackle health inequalities.
- Strategic Health Authorities should engage with the Football Foundation's regional planning process, ensuring that the health needs of local populations are accurately reflected. Strategic Health Authorities should also work with PCTs to encourage more applications to the Foundation for health-focussed projects.
- Given the cross-government nature of health inequalities and the cross-cutting role that football can play in tackling these, a health minister should be identified who can act as an ambassador for football and wider sport to the Department of Health and the NHS.

January 2008

Memorandum by the Improvement Foundation (HI 53)

THE EXTENT TO WHICH THE NHS CAN HELP TO ACHIEVE A REDUCTION IN HEALTH INEQUALITIES

EXECUTIVE SUMMARY

1. The Healthy Communities Collaborative run by the Improvement Foundation is a proven method of addressing health inequalities. It focuses on small populations with the greatest need. Members of the public are not simply consulted but constructively engaged and empowered to actively lead and drive improvement in their own community's health and well-being. Health, local authority and other agencies, including the voluntary sector, are then orientated around the population in order to support the required changes. Remarkable successes have already been achieved in reducing falls in older people and improving access to a healthy diet and work is already being undertaken to identify people at risk of cardio-vascular disease and people with symptoms suggestive of cancer. It is an approach that could easily be applied to any topic but obesity, alcohol misuse and access to primary care would be ideal.

THE IMPROVEMENT FOUNDATION

2. The Improvement Foundation (IF) is a not-for-profit organisation working across the NHS and other public services to support service improvement. We have been running successful improvement programmes since 2000, forging a credible reputation with primary care and other service providers, and working with local community members. Successes include improving access and chronic disease management in primary care, and the management of patients with more complex, multiple conditions especially in older people.

We have enhanced practices' abilities to maximize the benefits of practice based commissioning and helped people living in deprived communities, with high levels of morbidity and mortality, to improve the health of their community. We have the devolved structure necessary, with our 10 regional IF Centres, to work locally, regionally and nationally with front-line staff to develop capacity and capability for improvement.

3. Our method is to bring together experts and those achieving good results in a given topic area to tease out the characteristics of their systems that produce a better outcome. From that, we identify the key change principles (which if replicated by others will result in similar good practice) and monthly measures that participants report on. We are very focused on measurement as we see it as a key part of the process, without which we will never know if there has been an improvement. The next step is to expose people working in the field to the examples of good practice, the change principles and the measures and help them implement and measure change in their own working environment. We teach them a variety of quality improvement techniques, and we roll-out and spread the improvement across the entire country via our ten IF Centres.

4. We think it would be helpful to describe one of our specific programmes, the IF Healthy Communities Collaborative, which was set up to help the NHS to achieve a reduction in health inequalities and relates to the issues you are examining.

THE INEQUALITIES CONTEXT

5. Strategies to address health inequalities have recognised in recent years the need for partnership working which is vital in addressing some of the social, economic and environmental factors which contribute to poor health. In many of these existing partnerships, however, an important element is missing—that of the community as a significant partner. There are well recognised barriers to involving local people, some of these emanate from the professionals involved and some from the community itself. These barriers in the community become apparent when attempting to engage people who are not “the usual suspects” in public and patient involvement, people who may well lack the confidence and self esteem to get involved.

COMMUNITY ENGAGEMENT AND TACKLING INEQUALITIES: IF HEALTHY COMMUNITIES COLLABORATIVE RESULTS

6. The Improvement Foundation (IF) Healthy Communities programme has won national awards for its innovative work and results, and has become internationally recognised as leading the field in the area of involving deprived communities in the improvement of their own health and wellbeing.

7. In a recent NICE review of the use of community engagement, the IF Healthy Communities work was identified not only as successful in improving health outcomes but also one of the few national programmes that could identify the cost effectiveness of community engagement through a focus and attention to measurement of results.

8. The results of what local people can achieve when working in partnership with a range of agencies has been staggering.

9. For example, the initial focus of the programme was Falls Reduction in Elderly People. In just three sites covering a population of 150,000 there has been a 32% reduction in falls (730 fewer falls over 2 years). This amounts to reduction in hospital costs of £1.2 million pounds, ambulance costs of £120,000 and residential social care of £2.75 million pounds. This gives a total £4 million over two years or £2 million a year saved just for these small populations.

SOCIAL CAPITAL RESULTS

10. IF Healthy Communities also produces a gain in social capital within the overall community in which the improvement activity takes place. In the general population for Wave 1 sites (falls) following the work of the programme there was:

- 12% increase in people's perception of whether their area was a good place to live
- 12% increase in people's perception of whether individuals show concern for each other.
- 22% increase in the number of people who knew where to get advice about falls
- In participants active in the programme there was a 48% increase in the number of people who thought they could change and improve things in their communities.

11. Subsequent work addressed “Improving Access to a Healthy Diet”. A few of the many examples of success stories are illustrated below as case studies.

12. We are now testing the Healthy Communities approach with two new topics, promoting early presentation of cancer symptoms and early assessment of the risk of cardiovascular disease in deprived communities in spearhead PCTs with deprived communities.

13. Dealing with minor ailments and improving primary care access and responsiveness for black and minority ethnic groups could easily be tackled with this approach, as well as addressing obesity, alcohol and other public health issues.

THE IMPORTANCE OF COMMUNITY MEMBERS AS A RESOURCE

14. The IF Healthy Communities programme recognises that people need to be encouraged and supported to contribute and to feel valued as contributors. When they are, their contributions to solving problems are imaginative and innovative, and often very simple. They have a way of looking at solutions from the receiving end. An early lesson for us was learned after a meeting to recruit members of a community. One evaluation form came back with the following quote: "I haven't been to school for 60 years. How can I be of any use here?" That person had a wealth of knowledge and experience, not least about his own small community, as well as ideas about how things might be done differently to achieve more responsive service delivery.

15. Below is a quotation from a community member of an IF Healthy Communities Team describing how her confidence has grown as a result of taking part.

16. Joining the Healthy Communities Collaborative

"As from July my confidence was about to take a huge leap. I became involved with the Cancer Awareness, this is something that I have taken a real interest in, and it has really opened my eyes to the problems that many people have to face. I'm finding it very rewarding and worthwhile; it has given me confidence I never thought I had. . . . The contributions I make to the collaborative are appreciated. I honestly feel that the more I give, the more I receive back. I know I am part of a great team where your ideas, thoughts and opinions are considered. We get on very well and when at meetings or conferences we work hard and after the important things have a good laugh. As you may of noticed my confidence is growing and I would like to thank all the team for helping me . . ."—Community Member (Name can be supplied) Birtley Team, November 2007.

17. We actively support people with their personal development, bringing their confidence to levels where they are no longer afraid to speak up in groups, and can articulate their ideas and proposals in front of a range of professionals. We do this by teaching them some basic tools. Top of the list of these is the improvement methodology, but before this can be applied effectively, people have to understand their communities. They need to identify current service provision and the systems which operate (and which sometimes seem to be having an adverse effect on their expectations). We help community members to identify and understand the barriers to care. To help with this we teach community mapping techniques, participatory appraisal and process mapping.

18. We also get the local people to present their findings in public, describing how they have addressed some of the gaps in service provision. This is done very much in partnership with the professionals who support the community members in their drive to improve health and well being.

19. In one example, a team member living alone had never left the country or owned a passport. During her first year as a community team member, she instigated a phenomenal amount of work to improve elderly care provision in her area, and was invited by IF to present this work to an international conference in Copenhagen. She successfully described to the international audience the power unleashed in her community by the Healthy Communities approach in a single year. It was her first time in an aeroplane and she was 81 years old.

20. Another area which is addressed by the Healthy Communities approach is that of raising expectations—of life in general, life expectancy and quality of primary and secondary care provision. We start by pointing out the stark difference between the deprived areas we are targeting and the national average. We then go on to show how big the difference is when compared to the best communities in England. We create anxiety in these communities about their health status, using this as a spur for them to find their own solutions. For many people, this is the first time they have been made aware of their community's situation in a way which is understandable. The population sizes we work with (8–10000) make the statistics a reality for them. We can then begin to make them want to improve things which will lead to better health and well-being.

HOW THE HEALTHY COMMUNITIES COLLABORATIVE RECRUITS COMMUNITY MEMBERS

21. The recruitment of community members does not happen without preparation and forward planning. The partner organizations, having been identified beforehand by IF, meet to develop a profile of their local populations, using small area data on age, sex, ethnicity and socio-economic features and incorporating local knowledge. The profiling is matched to the subject matter. Our strategy is to identify the groups which would yield possible members. For example, if the subject for intervention is of particular relevance to older people, we would begin by targeting the networks and support groups, both statutory and voluntary, which serve older people. We then enlist the organizations who are the stakeholders to invite 50 or more people to an orientation event.

22. Invited participants are given the information they need to decide whether they would be interested in joining, but at the same time we give them the reasons why their particular areas have been selected, and present their local poor health statistics in comparison with the average and the best. This raises their anxieties and motivates them into wanting to be part of the changes.

HEALTHY COMMUNITIES SUSTAINABILITY

23. What keeps the people involved is just as important. It is made clear that no one organization or individual is more important than another. This is not the usual volunteering scenario. The volunteers are valued for their contribution, and at the same time it is made clear that local people will take the lead in the work, which is supported throughout by professionals. They feel that they have some control over finding solutions to long standing problems.

24. Their gains include enhanced social networks, increased confidence and new skills and knowledge which in some cases can lead to opportunities for employment or further study

25. Since the first sites were chosen in 2002, there have been 18 IF healthy communities programmes, all in different areas of England and three in Scotland, working either on falls, widening access to a healthier diet or both. Only one of these 21 sites has failed to sustain the work in one form or another.

26. The value of the HCC model has been recognised by the stakeholders in the participating sites in addressing both the topics of falls and healthy eating, and in the wider social exclusion agenda.

27. In most areas, the initial topic for engagement has developed and widened. One common area for development has been in drawing up strategies for older people's health and well-being, but the model adds value and substance to the implementation of local and national strategies and policies.

28. Critical Success Factors in Sustainability:

- When the collaborative programme has run its course, continuation costs are minimal, and in the main consist of funding for a project manager.
- The collaborative method ensures a legacy of knowledge and experience in the participating communities in the subject areas, specifically, but also in community development and social inclusion. Given the right nurturing environment, this becomes a formidable resource.
- The programme concentrates on bringing together individuals and organisations, which form new and strong networks with experience of working together.
- Local people develop new found confidence to continue and expand in areas of importance to their health and social welfare.
- The methodology taught to the teams gives them a tool which they can apply to any topic for improvement.
- There are quickly demonstrable outcomes which confirm the value of the work to individuals, organisations and likely commissioners.
- The template for joint working which is at the heart of the Healthy Communities Collaborative approach, allows for efficient and effective use of resources.

STRATEGIC DEVELOPMENT

29. Where a Healthy Communities programme has become well established and its value recognised, it has become a model for service delivery through Local Area Agreements. There are excellent examples of this in Northampton, Gateshead, Sunderland and Salford. In other areas funding from various sources has been identified for the continuation and expansion of the work. Current work strands which are focused on cardio-vascular disease and cancer awareness, are already being planned into sites' strategies at the start so they will continue after the IF Programme has ceased.

CONCLUSION

30. The IF Healthy Communities Collaborative has worked with people in the most disadvantaged areas in England and successfully engaged residents in these areas to work alongside service providers and the voluntary sector. We believe that health is everyone's business and that there are untapped and unrecognised resources in every community. We ensure by our approach that these come to the fore in the battle against health inequalities.

31. *Improvement Foundation Healthy Communities Case Studies*

Targeting Young Families, Easington HCC

The Healthy Communities Team in Haswell, County Durham were aware that many mums with young families did not know how to shop for, prepare and cook meals with fresh produce. They also were aware that people in the area live on very low incomes. Trying a new meal therefore involves a considerable amount of risk, as if it is not liked the family go hungry.

They tackled this risk by organising a free 8 week course for mothers in the area to learn how to make a healthy meal. This was done in conjunction with a local butcher who could supply fresh meat for the course and give advice on cooking it. The Primary Care Trust agreed to cover his costs through a voucher scheme and to provide the other ingredients. This pre-empted the Healthy Start voucher scheme, due to be introduced nationally in the following year.

The team contacted the mums 9 weeks after the course to monitor the outcomes and offer further advice and support. They were delighted to discover that all but one of the participants were using their new skills and continuing to patronise the local butcher and food co-op.

Grow Active Allotment Scheme, Blackburn with Darwen HCC

There's nothing like growing your own fruit and vegetables to understand food. The Healthy Communities Team in Blackburn with Darwen has put this into practice with the Grow Active Allotment Scheme.

Following a successful allotment initiative led by the local authority the teams have helped develop a new plot on Bangor Street. The plot was cleared, a large shed erected, paths cleared and raised beds built in order to provide easy access for a broad range of people. Seeding, growing and sharing the produce has improved participants access to and knowledge of fresh food. In addition, it has helped bridge boundaries between different age groups and communities. It does this in a peaceful, colourful setting, in which team member's hard work is rewarded with satisfaction of growing your own food.

From this project, the community was spurred on to continue with its improvements in lifestyle and integration. The teams went on to apply for lottery funding to revive and bring up to standard, an outdoor bowling green. The membership is focused on involving different racial and cultural groups and on involving young people in this form of exercise.

Before and After School Club in Gateshead

This initiative took place in an ex-mining village, counted as one of the 20% most deprived communities in England, in a pre-school nursery which provides a breakfast club and after school facilities for children from age 3.

The Healthy Communities teams decided to target this group with the aim of improving the general nutrition of the children attending the nursery. A significant proportion are children in need or at risk, according to social services criteria. The staff provide both a breakfast club and an after school facility where snacks are served. These were mostly fizzy drinks, crisps, chocolate and sweets. There was never a direct intention to affect the behaviour of the children at the nursery, but to improve their nutritional intake. The concern was greater because, for many of the children, the after school snack was the last food they were offered in the day.

The work began by introducing fruit as an alternative to sweets, and the team bought a smoothie maker to enable nursery staff to replace the fizzy drinks on offer. The children quickly became fans of smoothies, and then began to accept raw vegetables with dips as snack foods. The school staff noticed (without prompting) a difference in the children's behaviour. The head teacher remarked on how much calmer the children were becoming as the consumption of junk food lessened.

At the AGM the decision was taken that confectionery products should not be available at all at the after school club for 2 out of 5 days a week. Some parents were asking for a complete ban, because of the improvement in the behaviour of their children.

At the same time, the nursery introduced breakfasts of fresh fruit, yoghurt and wholemeal toast. There was a noticeable difference in the levels of fatigue and alertness in the children at the start of the school day.

Memorandum by Professor Hilary Graham (HI 54)

HEALTH INEQUALITIES

EXECUTIVE SUMMARY

1. The term “health inequalities” describes a social gradient in health in which each step up the socioeconomic ladder, from the most disadvantaged to the most advantaged, is associated with progressively higher standards of health. The “health gap”—defined in England’s targets as the difference between the health of disadvantaged groups and the population average—is one aspect of the health gradient.

2. Health gradients and health gaps are widely acknowledged to be unjust and unfair. International charters commit UK governments to pursuing policies which level up opportunities for everyone to enjoy the standards of health currently the preserve of the most advantaged groups.

3. Health inequalities are persisting despite record-breaking levels of wealth and health in the UK. Moreover, the evidence points to widening health inequalities. The trend reflects the slower rate of health gain in more disadvantaged groups. As a result, health gaps have been widening and health gradients have been steepening.

4. The major determinants of health lie beyond the NHS in people’s living and working conditions and health behaviours. Inequalities in health are the outcome of the unequal distribution of these determinants. Advantaged groups enjoy greater access to the determinants of good health; disadvantaged groups experience greater exposure to the determinants of poor health, chronic disease and premature death.

5. Behind widening inequalities in health lie widening inequalities in health determinants. Over the last 30 years, inequalities in key determinants like living standards and cigarette smoking have widened sharply—and currently show little sign of narrowing.

6. Widening inequalities in health determinants reflect a mix of factors. These include a shift to less redistributive economic policies and the absence of strong regulatory policies with the potential to curb uptake and consumption of health-damaging products like cigarettes in disadvantaged groups. These factors are amenable to government policy.

1. INEQUALITIES IN HEALTH TAKE THE FORM OF A SOCIAL GRADIENT

1.1 The UK is scarred by deep socioeconomic inequalities in health.

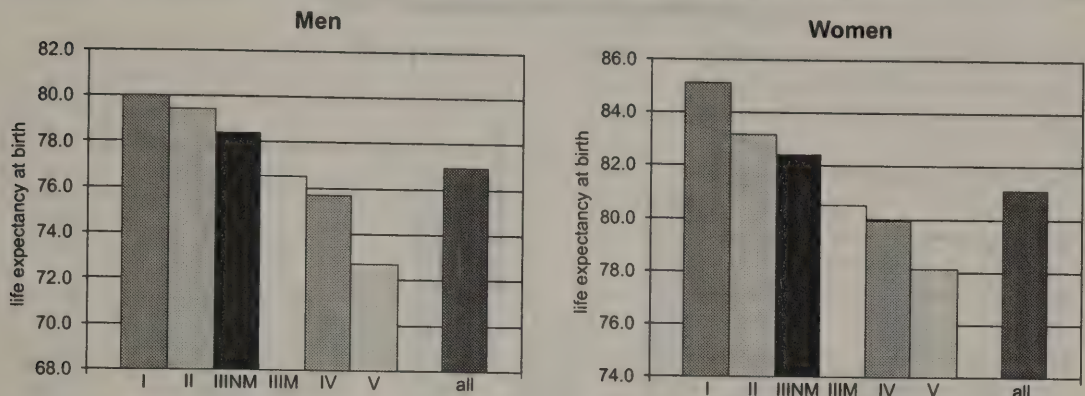
1.2 These inequalities take the form of a social gradient. Those in the most advantaged circumstances enjoy the highest standards of health: they are least at risk of disability in childhood and adulthood and of chronic disease and premature death. Standards of health are lower for those in less advantaged circumstances, and decline in stepwise fashion as levels of disadvantage increase.

1.3 The health gradient is illustrated in Figure 1. It takes life expectancy as the measure of health, and social class based on occupation as the measure of people’s socioeconomic circumstances. Occupational social class was the official measure of people’s socioeconomic circumstances from 1911 to 2000 when it was replaced by a new schema, the National Statistics-Socioeconomic Classification (NS-SEC)⁴⁰⁰; occupational social class therefore provides the best measure of trends in health inequalities.

1.4 Figure 1 also captures the health gap between the most disadvantaged group (social class V, unskilled manual) and both the most advantaged group (social class 1, professional) and the population average (all). These are indicated in darker shades.

⁴⁰⁰ NS-SEC categorises occupations in a different way and is used for England’s health infant target for infant mortality.

Figure 1: Life expectancy at birth by social class, England & Wales, 2002–05



Source: ONS, 2007.⁴⁰¹

1.4 As Figure 1 indicates, health gradients exist for men and women. They are evident at all points in the life course and exist across both the majority white population and among minority ethnic groups.

2. HEALTH GRADIENTS AND HEALTH GAPS ARE UNJUST AND UNFAIR

2.1 Socioeconomic inequalities in health have long been acknowledged to be inequitable: to be unfair and unjust. In 1946, the World Health Organisation (WHO) was established under the UN Charter. It is founded on the principle that “every human being without distinction of race, religion, political belief, economic or social condition” has the fundamental right to achieve “the highest attainable standard of health”⁴⁰². The principle has been repeatedly reasserted in international charters and in European strategies to which the UK Government has again been a signatory.

2.2 The principle is commonly understood to mean that everyone in a society should have an equal chance of reaching the standards of health which are currently the preserve of the well-off. In policy terms, it means a commitment to “leveling up”: to lifting levels of health across the socioeconomic hierarchy to those attained in the highest socioeconomic group.

3. HEALTH INEQUALITIES ARE PERSISTING AND WIDENING DESPITE RECORD-BREAKING LEVELS OF WEALTH AND HEALTH IN THE UK

3.1 Over the last 30 years, living standards have risen rapidly and life expectancy has improved steadily. But the policy mix which has made the UK population wealthier and healthier has failed to level up opportunities between socioeconomic groups to live a long and healthy life.

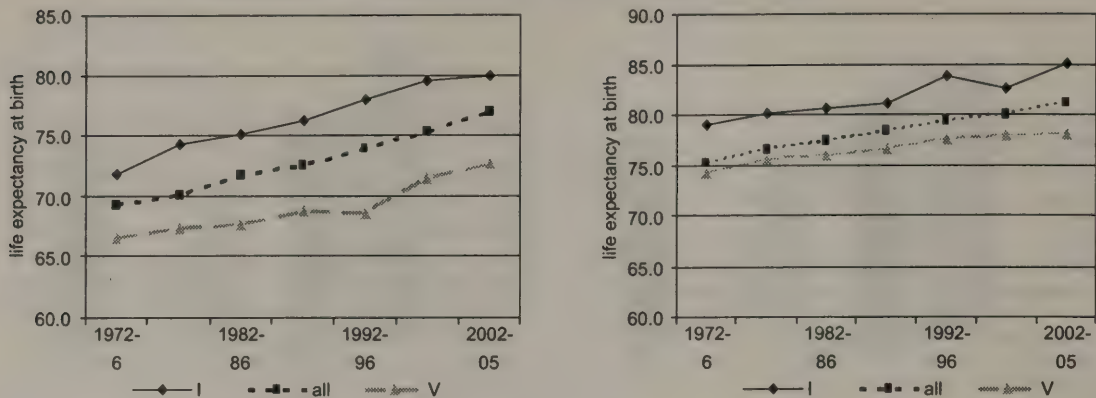
3.2 Instead, inequalities in health have persisted. Moreover, the evidence points to widening inequalities in the risk of ill-health and premature death in recent decades. The Government’s goal of reducing inequalities therefore requires first a halt, and then a reversal, of a long-running trend.

3.3 The trend reflects the fact that health in more disadvantaged groups is not improving as rapidly as in more advantaged groups. There has been a differential rate of health gain, with rates of improvement in more advantaged groups outstripping rates in more disadvantaged groups. As a result, health gaps are widening and health gradients are steepening. This trend is captured for life expectancy in Figure 2.

3.4 England’s health inequalities targets focus on narrowing the gap between disadvantaged groups and the population as a whole and, specifically, on reducing infant mortality rates in lower socioeconomic groups and lifting life expectancy in disadvantaged areas closer to the national average by 2010. The latest data indicate that infant mortality rates have fallen and life expectancy has risen in the target groups from the baseline period of 1997–99. However, the rate of improvement has continued to be greater in the population as a whole. As a result, the long-term trend has been maintained rather than reversed, and the relative gap in both indicators has widened over the last decade^{403, 404, 405}. This suggests that the Government is unlikely to meet its PSA targets in respect of health inequalities.

⁴⁰¹ Office for National Statistics. 2007, London: ONS.
⁴⁰² World Health Organisation, *Constitution of the World Health Organisation*. 1946, London: WHO.
⁴⁰³ Department of Health, *Tackling Health Inequalities: Status Report on the Programme for Action*. 2005, Department of Health: London.
⁴⁰⁴ Department of Health, *Tackling Health Inequalities: Status Report on the Programme for Action—2006 Update of Headline Indicators*. 2006, London: Department of Health.
⁴⁰⁵ Department of Health, *Tackling Health Inequalities: 2004–06 data and policy update for the 2010 National Target*. 2007, London: Department of Health.

Figure 2: Life expectancy at birth for men & women in social class I (professional), social class V (unskilled manual) and all, 1972–2005, England & Wales



Source: ONS, 2007.⁴⁰⁶

3.5 It is important to note that England’s health inequalities targets exclude groups at high risk of infant death and premature death. For example, the infant mortality target focuses on jointly-registered births where the father has an occupation in the NS-SEC “routine and manual” group. Babies born to other groups of parents, including those solely registered by the mother and jointly registered to parents where the father is long-term unemployed or has never worked, have appreciably higher infant mortality rates⁴⁰⁷.

4. INEQUALITIES IN HEALTH ARE THE OUTCOME OF INEQUALITIES IN HEALTH DETERMINANTS

4.1 It is widely recognised that individual and population health is shaped by a web of social influences. This web is often referred to as the social determinants of health.

4.2 While there is a range of models of the social determinants of health, they conform to a common format. In these models, the social determinants of health have their origins in:

- The overarching structure of society, which includes its labour market, education system, tax and benefit systems etc. This structure shapes the conditions in which people live their lives, in childhood, through adulthood and into old age.
- People’s living and working conditions, as measured by occupation, household income, area deprivation etc. These conditions are shaped by wider societal factors and they mediate access and exposure to a set of intermediate risk factors which have more direct effects on health. Living and working conditions are therefore identified as the pivotal determinant of health.
- Intermediate risk factors include the social and material environment of the home, neighbourhood and workplace, which both provide resources for health and contain risks for health. Intermediate factors include, too, behaviours which can be either health protecting and enhancing (like exercise) or health damaging (like cigarette smoking and energy dense/nutrient poor diets).

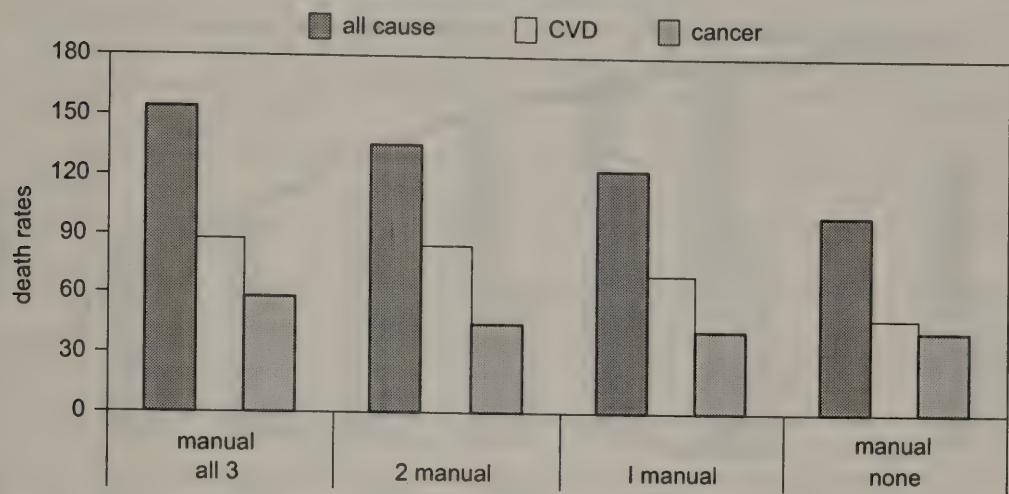
4.3 Social determinants influence health from before birth and across life. How long an individual lives in advantaged or disadvantaged conditions therefore matters for their health. Figure 3 is based on a Scottish study which used information on social class at three time-points—at the time the study participant was born, when they first entered the labour market and their occupation in mid-life—to allocate men to a manual or non-manual social class across their lives⁴⁰⁸. A graded association was revealed between cumulative social class and all-cause mortality. Thus, men in a manual social class at all three time points—the largest group—had the highest mortality rate over the 21 years of follow-up. Mortality rates fell progressively for men who spent smaller proportions of their lives in the manual group.

⁴⁰⁶ Office for National Statistics. 2007, London: ONS.

⁴⁰⁷ Department of Health, *Tackling Health Inequalities: Status Report on the Programme for Action—2006 Update of Headline Indicators*. 2006, London: Department of Health.

⁴⁰⁸ Davey Smith, G., et al., *Lifetime socioeconomic position and mortality: prospective observational study*. BMJ, 1997. 314(7080): p. 547–52.

Figure 3: Age-adjusted death rates (per 1000 person years) over 21 years of follow-up by cumulative social class, men age 35–64, Scotland



Source: Davey Smith, 1997.⁴⁰⁹

4.4 Death rates from cardiovascular disease and cancer displayed a similar pattern (Figure 3). Men born into and remaining in the manual group experienced the highest rates of death from these diseases; rates were lower for those who spent longer periods in more advantaged class positions⁴⁰⁹. A similar pattern is also revealed in the 1958 British birth cohort study for physiological risk factors for chronic disease in mid-life, including BMI, cholesterol, chronic widespread pain and depressive symptoms⁴¹⁰. As this suggests, “lifetime” socioeconomic position—measured from birth to adulthood—is a powerful predictor of adult disease and mortality risk⁴¹¹.

4.5 While people’s circumstances across their lives matter for their health, childhood circumstances have been found to be particularly important. Figure 4 describes the patterns for premature mortality. Based on the 1946 British birth cohort study, it plots the survival of children from manual and non-manual backgrounds from the age of 26 (312 months), when almost all children were still alive, to age 54 (648 months). It captures the marked socioeconomic differentials in survival, with death rates among women and men born into manual households double those of women and men growing up in non-manual households. Their increased risk of death was little reduced after account was taken of socioeconomic circumstances in adulthood: in other words, the effect of poor circumstances in childhood was independent of whether adulthood brought continuing disadvantage or better circumstances⁴¹². What is evident for all-cause mortality is repeated for a number of specific causes of death. For example, childhood disadvantage has been found to make a significant contribution to the risk of cardiovascular disease, over and above the effects of adult social class⁴¹³.

⁴⁰⁹ Davey Smith, G., et al., *Lifetime socioeconomic position and mortality: prospective observational study*. *BMJ*, 1997. 314(7080): p. 547–52.

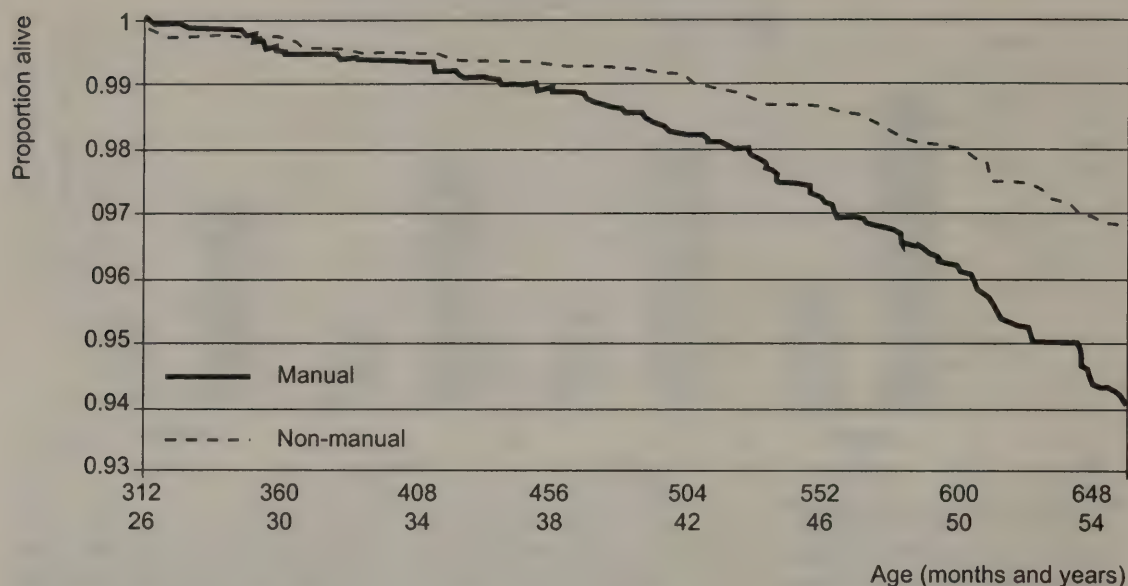
⁴¹⁰ Power, C., et al., *Life-course influences on health in British adults: effects of socio-economic position in childhood and adulthood*. *International Journal of Epidemiology*, 2007. 36(3): p. 522–531.

⁴¹¹ Blane, D., et al., *Association of cardiovascular disease risk factors with socioeconomic position during childhood and during adulthood*. *British Medical Journal*, 1996. 313: p. 1434–8.

⁴¹² Kuh, D., et al., *Mortality in adults aged 26–54 years related to socioeconomic conditions in childhood and adulthood: post war birth cohort study*. *British Medical Journal*, 2002. 325(7372): p. 1076–80.

⁴¹³ Lawlor, D.A., Y. Ben-Shlomo, and D.A. Leon, *Pre-adult influences on cardiovascular disease*, in *A Life Course Approach to Chronic Disease Epidemiology*, D.L. Kuh and Y. Ben-Shlomo, Editors. 2004, Oxford University Press: Oxford.

Figure 4: Cumulative death rates age 26 to 54 by father's social class at birth among men and women in the 1946 birth cohort study



Source: Kuh *et al.*, 2002.⁴¹⁴

4.6 The circumstances in which children are conceived, are born and grow up matter for their health because childhood conditions influence both socioeconomic circumstances and health in adult life. With respect to future circumstances, children born to professional parents are more likely to do well at school and progress to a secure, rewarding and well-paid career than those growing up in families lower down the social scale—and these inequalities in future prospects have been widening not narrowing. They are also less likely to follow domestic trajectories like early and lone parenthood which increase the risk of disadvantage in adult life—and increase the risk that their children will also face a lifetime of disadvantage.

4.7 With respect to future health, childhood circumstances matter because early life is a period when children's body systems mould and adapt to the environments in which they are developing. While the development process is genetically regulated, how genes are expressed is determined by the child's physical and social environment⁴¹⁵. The process is described as "embodiment" and "biological embedding" by epidemiologists⁴¹⁶. Experiences which are physically and emotionally nurturing become written into bodily structures and functions in ways which promote and protect their future health. Conversely, environmental adversity in the early years of life has been found to induce long-term patterns of physical, cognitive and emotional development which leave children vulnerable to developmental delay and poor health.

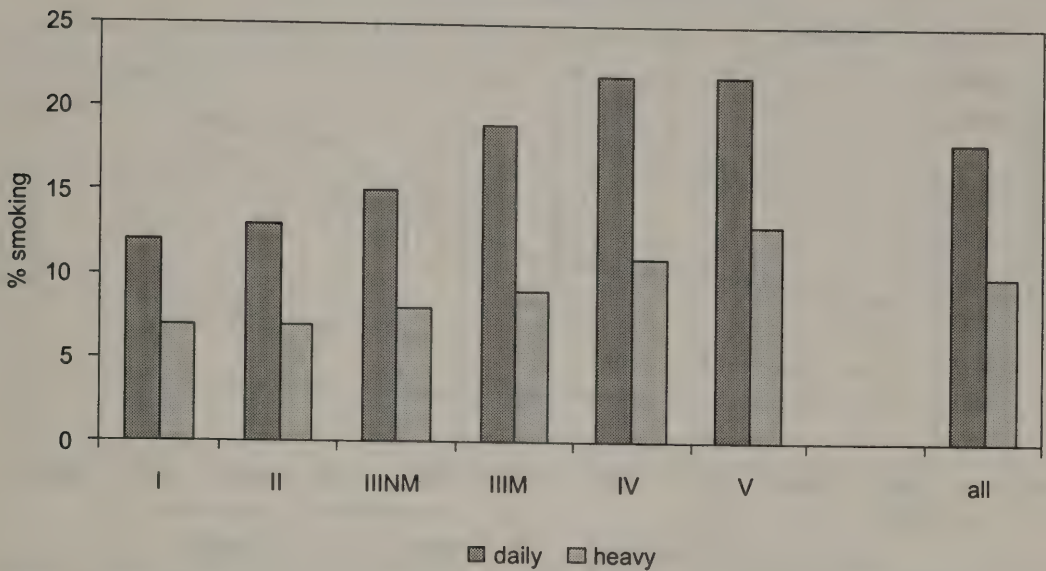
4.8 Health behaviours are also often set in childhood and then track into adulthood. For example, adolescence is the critical period for uptake of cigarette smoking. Young people growing up in disadvantaged circumstances are more likely than their advantaged peers to become regular smokers (Figure 5)—and to continue to smoke, and smoke heavily, through adulthood.

⁴¹⁴ Kuh, D., *et al.*, *Mortality in adults aged 26–54 years related to socioeconomic conditions in childhood and adulthood: post war birth cohort study*. *British Medical Journal*, 2002. 325(7372): p. 1076–80.

⁴¹⁵ Halfon, N. and M. Hochstein, *Life Course Health Development: An Integrated Framework for Developing Health, Policy, and Research*. *The Milbank Quarterly*, 2002. 80(3): p. 433–479.

⁴¹⁶ Kuh, D., *et al.*, *Life course epidemiology*. *Journal of Epidemiology and Community Health*, 2003. 57(10): p. 778–783.

Figure 5: Prevalence of daily and heavy smoking among young people aged 15 by parental social class, Scotland, 1999



Notes: (1) daily smoker reported smoking ≥ 7 cigarettes a week and heavy smokers reported smoking ≥ 35 cigarettes a week (2) parental social class based on occupation of head of household. Source: Sweeting and West, 2001.⁴¹⁷

4.9. Taken together, the evidence on health determinants suggests that the NHS plays a secondary role in influencing people’s health and reducing health inequalities. Services which screen and treat those at risk of early death are important but, on their own, they can not change the social conditions which generate risk in current and future generations. The DH emphasises the responsibility of local NHS services to meet England’s health inequalities targets; there is a strong argument for shifting responsibility for delivery of the PSA health inequalities targets to Government departments with capacity to reduce inequalities in living conditions.

5. WIDENING INEQUALITIES IN HEALTH ARE ASSOCIATED WITH AN INCREASINGLY UNEQUAL DISTRIBUTION OF HEALTH DETERMINANTS.

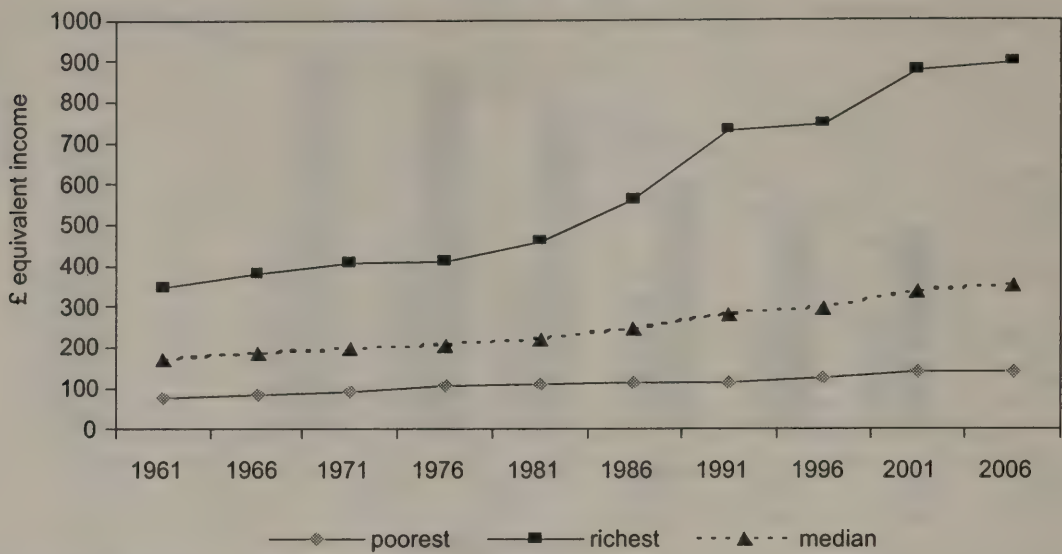
5.1 It is widely accepted that inequalities in health are the outcome of inequalities in health determinants, operating along the causal chain from the overall structure of society, through people’s living and working conditions to their health behaviours (see paras 4.1–4.2).

5.2 Over the last 30 years, inequalities in key determinants of health have widened sharply—and currently show little sign of narrowing. Inequalities in living conditions (as indexed by living standards) and in health behaviours (cigarette smoking) provide two examples.

5.3 Living standards are measured by disposable household income (income after direct taxation and cash transfers). Evidence for the 1940s and 1950s points to narrowing inequalities in household income, with richer households seeing their share of national income fall. Figure 6 picks up the story in the early 1960s, and suggests that, until the mid-1970s, income inequalities in Britain were marked but stable. From the late-1970s, real incomes at the upper end of the income distribution set off on a sharply upward trajectory; the incomes of the poor, meanwhile, stagnated. The trend has slowed since the early 2000s but has yet to be reversed.

⁴¹⁷ Sweeting, H. and P. West, *Social class and smoking at age 15: the effect of different definitions of smoking*. *Addiction*, 2001. 96(9): p. 1357–1359.

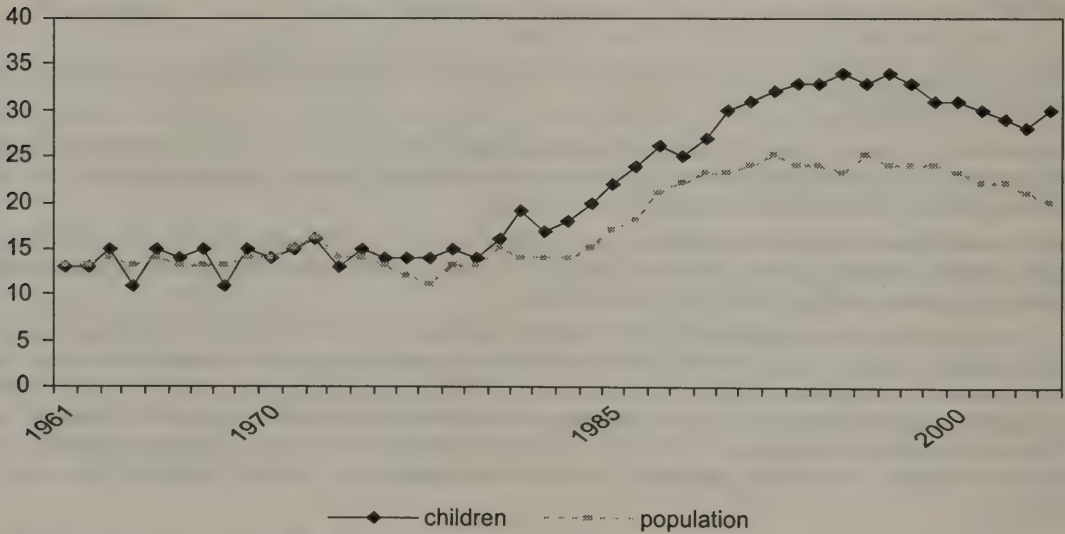
Figure 6: Weekly real household incomes: median income, poorest 10%, richest 10%, before housing costs, Britain, 1961–2006



Source: FES, IFS analyses.⁴¹⁸

5.4 Because children are disproportionately represented among lower-income households, the trend towards wider income inequalities has disproportionately impacted on children. Rates of child poverty rose rapidly from the early 1980s (Figure 7). Because exposure to poverty in childhood has lifelong effects on future health (see paras 4.5–4.8), we should anticipate that rising rates of child poverty through the 1980s and 1990s will “cast long shadows forward” over the health of these cohorts as they grow older.

Figure 7: Population and child poverty rates (% in households below 60% median income, after housing costs) Britain, 1961–2004/05



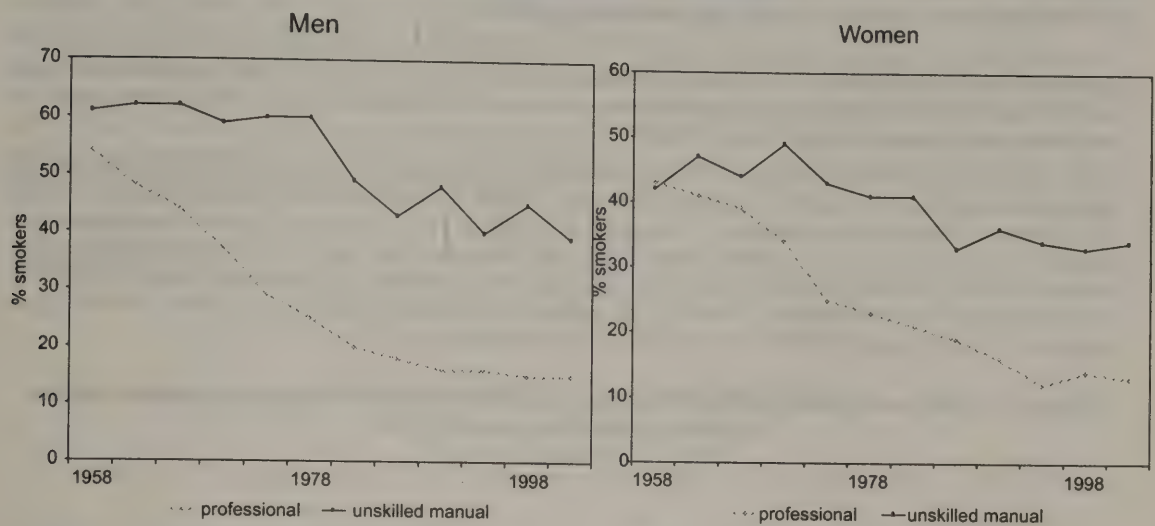
Source: IFS, 2006, DWP, 2007.⁴¹⁸

5.5 Interventions like Sure Start and Health Action Zones are operating against the trend of widening inequalities in living standards. It should not surprise us that interventions which seek to reduce inequalities in health by tackling behavioural factors (eg parenting skills, infant feeding practices, cigarette smoking) are struggling to make a dent on inequalities in either the targeted risk factor or in health.

5.6 Cigarette smoking provides a second example of widening inequalities in determinants. The downward trend in smoking prevalence has been associated with a steepening social gradient, with a later and slower rate of decline in prevalence in more disadvantaged groups. Figures 8 and 9 capture the widening of inequalities in smoking from 1958–2000 (based on social class) and continuing inequalities from 2001 (based on NS-SEC). In consequence, inequalities in cigarette smoking make a major contribution to health inequalities.

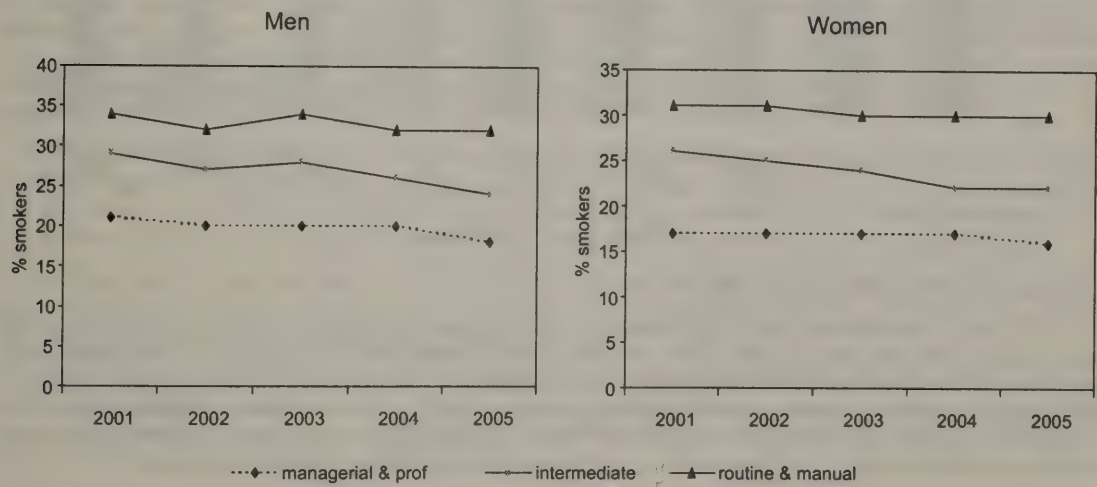
⁴¹⁸ Institute for Fiscal Studies web site, *Inequality, poverty and well-being spreadsheet*. Accessed December 2008, www.ifs.org.uk/projects_research.php?heading_id=8_.

Figure 8: Prevalence of cigarette smoking in the highest (professional) and lowest (unskilled manual) socioeconomic groups, Britain, 1958–2000



Source: Wald and Nicolaides-Bouman, 1991, Table 5.2⁴¹⁹; ONS, 2001, Table 8.8.⁴²⁰

Figure 9: Prevalence of cigarette smoking by socioeconomic classification of the household reference person, 2001–05, England: managerial and professional group, intermediate group, routine and manual group



Source: ONS, 2006.⁴²¹

6. WIDENING INEQUALITIES IN HEALTH DETERMINANTS REFLECT A MIX OF FACTORS AMENABLE TO POLICY INTERVENTION

6.1 Policies to tackle inequalities in health encompass those which moderate inequalities in the social structure (in the education system, labour market and the wider distribution of property and wealth), in people's living and working conditions and in environmental and behavioural risk factors. Governments exercise considerable influence over the magnitude of these inequalities. Inequalities in living standards and in cigarette smoking provide two examples.

6.2 Because earnings are the major source of income for all households except those in lowest income deciles, a progressive direct tax system distributes income from rich to poor. Welfare benefits are the major source of income for poorest groups but represent a very small proportion of income of higher income

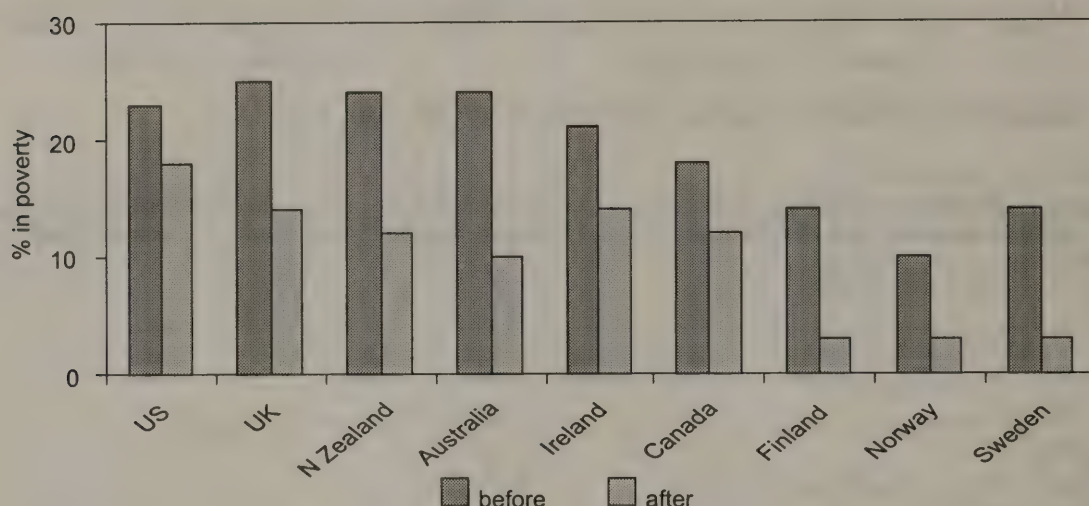
⁴¹⁹ Wald, N. and A. Nicolaides-Bouman, *UK Tobacco Statistics*. 1991, Oxford: Oxford University Press.
⁴²⁰ Office for National Statistics, *Living in Britain: Results from the 2000/01 General Household Survey*. 2001, London: The Stationery Office.
⁴²¹ Office for National Statistics, *Smoking and Drinking among Adults*, 2005. 2006, London: ONS.

groups, so welfare policies provide a lever through which to level up incomes. Through these two key policy instruments, inequalities in disposable income are less extreme than those in market income. In UK, benefits play the larger part in equalising incomes and living standards.

6.3 Analyses by welfare economists suggest that the trend towards widening inequalities in disposable household incomes (Figure 6) reflects changes in Government policies. Compared with the period from 1940 to 1980, the tax and benefit systems do less to moderate inequalities in market incomes. In consequence, inequalities in disposable income have widened.

6.4 The UK tax and benefit system is less effective in protecting the living standards of low-income households than those in other high-income countries. Figure 9 focuses on child poverty rates before and after direct taxation and cash benefits. It suggests not only are rates of poverty before income transfer appreciably lower in Nordic countries than in the UK, but also that national tax and benefit policies combine to offer a higher degree of protection from poverty. In Sweden, child poverty rates are over 70% lower after direct tax and benefits. In the UK, the proportion of children lifted out of poverty through these policy levers is appreciably lower: here, poverty rates are reduced by 46%.

Figure 10: Child poverty rates (below 50% median household income) before and after income transfers (direct tax and welfare benefits), 2000



Source: Whiteford and Adema, 2006.⁴²²

6.5 To date, redistributive income policies have not featured strongly in the UK's health inequalities strategy. However, they do in some other countries. For example, the first objective of the Norwegian's health inequalities strategy is to "reduce economic inequalities". It notes that "the Government is going to take steps to reduce economic inequalities in the population . . . The taxation system will be improved so it does more to ensure a fairer income distribution"⁴²³. Policies to achieve a fairer income distribution in the UK would provide a platform from which to tackle inequalities in other health determinants.

6.6 Turning to cigarette smoking, evaluating the effects of policies is not straightforward. Widening socioeconomic gradients in smoking (Figure 8) suggests that tobacco control policies in the 1970s, 1980s and 1990s—which relied heavily on warning smokers of the dangers of smoking—had differential effects, achieving larger reductions in prevalence in better-off groups than in disadvantaged groups. However, it is important to note that smoking rates were already declining in advantaged groups before tobacco control policies were first introduced in the 1970s (Figure 8). As this suggests, changes in the social profile of smoking are likely to occur independently of tobacco control policies, making evaluation of their additional contribution difficult to assess.

6.7 To address current socioeconomic differentials in smoking prevalence (Figure 9) requires tobacco control policies which are at least as effective in more disadvantaged groups as in better-off groups. There is suggestive evidence that these policies include population-wide policies which institute large and sustained increases in cigarette prices, comprehensive clean air laws, mandatory bans on cigarette advertising and promotion as well as well-funded public information campaigns^{424, 425}. The UK has instituted such policies over the last decade, with cigarette prices now among the highest in Europe⁴²⁵ and legislation prohibiting

⁴²² Whiteford, P. and W. Adema, *Combating Child Poverty in OECD Countries: Is Work the Answer? DELSA/ELSA/WD/SEM(2006)7*. 2006, Paris: OECD.

⁴²³ Norwegian Ministry of Health and Care Services, *National strategy to reduce social inequalities in health, Report No 20 (2006–2007) to the Storting*. 2007, Oslo: Norwegian Ministry of Health and Care Services.

⁴²⁴ Levy, D.T., F. Chaloupka, and J. Gitchell, *The effects of tobacco control policies on smoking rates: a tobacco control scorecard*. J Public Health Manag Pract, 2004. 10(4): p. 338–353.

⁴²⁵ Joossens, L. and M. Raw, *The Tobacco Control Scale: a new scale to measure country activity*. Tobacco Control, 2006. 15: p. 247–253.

smoking in public places and most forms of tobacco advertising. In addition, while England's NHS smoking cessation services only reach a small minority of smokers who try to quit each year and disadvantaged smokers have lower quit rates⁴²⁶, careful targeting means that they are helping proportionately more smokers in Spearhead areas than in other parts of the country⁴²⁷.

6.8 In combination, current tobacco control policies may break with the trend over the last 50 years and achieve a greater reduction in prevalence in lower socioeconomic groups—and thus narrow socioeconomic differentials in smoking. However, a policy programme which levels up life chances and living conditions across the population is likely to be a pre-condition for a wider reduction in inequalities in health determinants and a reduction in health inequalities.

Hilary Graham⁴²⁸

January 2008

Memorandum by the National AIDS Trust (HI 55)

HEALTH INEQUALITIES

EXECUTIVE SUMMARY OF RECOMMENDATIONS

1. The National AIDS Trust believes that the health inequalities agenda must look at the UK population in a variety of ways, including specific ethnicities, sexual orientation and residency status, as to better capture the various forms of inequality that exist.

2. Accepting that the Public Service Agreement target on reducing health inequalities will be with us until its timeline is completed, the National AIDS Trust believes that the Department of Health should look at how to incentivise a more inclusive consideration of health inequalities within local PCTs and nationally, so that the wider social determinants of health and those that cause health inequalities are also examined. This will rely on strong and effective partnership across Government agencies, local authorities, community organisations and other key stakeholders.

3. The National AIDS Trust asks the Health Committee to reaffirm its recommendations on charging as outlined in its *New Developments on Sexual Health and HIV/AIDS Policy* report, to end the discrimination against people with HIV in sexual health services, ensuring free treatment for all. This must be one of the Department of Health's primary concerns, providing free treatment for all to protect public health.

4. While much of the treatment of HIV infection is specialised, the National AIDS Trust believes that the Department of Health should look at how to scale up the important role GPs and primary care teams can play in the prevention, diagnosis and management of HIV infection.

5. The National AIDS Trust recommends that the Health Committee identify prison healthcare as a key opportunity and intervention to address health inequalities. In particular, prisons should support safer sex and safer injecting practices, both within prison and for the future life after custody, and provide accessibly clean needles and condoms to those who need them.

INTRODUCTION

1. The National AIDS Trust is the UK's leading policy and campaigning charity on HIV and AIDS. The National AIDS Trust develops policies and campaigns to halt the spread of HIV, and improve the quality of life of people affected by HIV and AIDS, both in the UK and internationally.

2. The National AIDS Trust welcomes the opportunity to provide input into the House of Commons Health Committee inquiry on the extent to which the National Health Service (NHS) can help to achieve a reduction in health inequalities, particularly for vulnerable people living with HIV.

3. This brief memorandum contains a background on the current situation as related to HIV in the UK and considers, in turn, four specific points: how inequality is assessed; whether this assessment adequately addresses the unequal burdens of ill health around long-term conditions, such as HIV; structural causes within the NHS of health inequalities; and prison health.

⁴²⁶ Ferguson, J., et al., *The English smoking treatment services: one-year outcomes*. Addiction, 2005. 100(s 2): p. 59–69.

⁴²⁷ Bauld, L., K. Judge, and S. Platt, *Assessing the impact of smoking cessation services on reducing health inequalities in England: observational study*. Tobacco Control, 2007. 16: p. 400–404.

⁴²⁸ Hilary Graham is Professor of Health Sciences, University of York. She has a background in social and public health research, was a member of the Acheson Inquiry into Inequalities in Health and is currently Director of the DH Public Health Research Consortium. Her submission is made in a personal capacity and draws on her book, *Unequal Lives: Health and Socioeconomic Inequalities*, published in October 2007 by Open University Press (<http://mcgraw-hill.co.uk/html/0335213693.html>).

BACKGROUND

4. The National AIDS Trust commends the Department of Health (DH) for putting the reduction of health inequalities high on the agenda of the NHS, both in terms of delivery and working with other agencies across Government, and for establishing a national Public Service Agreement (PSA) target in 2001 on reducing health inequalities. The PSA sets out to, by 2010, reduce inequalities in health outcomes by 10 per cent as measured by infant mortality and life expectancy at birth.

5. This commitment to reducing health inequalities is reinforced in the NHS Operating Framework 2008–09.⁴²⁹ The Operating Framework outlines reducing health inequalities as one of five key national priority areas for Primary Care Trusts (PCTs) by working with providers and their local partners. In fact, reducing health inequalities has featured as a key national priority each year in the Framework since 2003⁴³⁰ and was highlighted as a key theme during the UK presidency of the European Union in 2005.⁴³¹

6. Despite these commitments, there are still unacceptable variations in the health status within and between different communities, and the gap for some may, in fact, be widening.⁴³² It is now estimated that there are 73,000 people living with HIV in the UK, the highest number ever. Disadvantage and health inequalities are key issues for those most vulnerable to HIV infection, including migrants and men who have sex with men (MSM). For example, 40 per cent of black Africans and black Caribbeans living with HIV in the UK are diagnosed late. Gay and bisexual men show records rates of HIV infection, with an estimated 2,700 new diagnoses in MSM in 2006.⁴³³ In addition, research suggests less than half of people living with HIV are in paid employment, despite the effectiveness of treatments⁴³⁴ and one in three people diagnosed with HIV in the UK have experienced severe economic hardship.⁴³⁵

ASSESSING INEQUALITY

7. The DH “breaks down” inequality by looking at the areas with the worst health and deprivation as compared to the population as a whole. This agenda alone does not adequately address the experience of some groups in the UK. For example, black Africans, migrants and MSM are particularly vulnerable to HIV infection⁴³⁶, but the current inequality “break down” fails to analyse inequality by ethnicity or sexuality. To give a further example, evidence from a recent Confidential Enquiry into Maternal and Child Health report, *Saving Mothers’ Lives*, shows that black African women, including migrants, have a mortality rate nearly six times higher than white women and that HIV is a condition that contributes to maternal death.⁴³⁷ This inequality is currently overlooked by the DH’s approach. It is therefore vital that health inequalities are considered in terms of specific ethnicities, sexual orientation and residency status.

8. Such an approach could bring many benefits. As well as providing better data, it could facilitate important connections. For example, if gay men are also experiencing health inequalities around mental health problems, or drug and alcohol abuse, then this evidence could be used to develop a more holistic approach to addressing health promotion and HIV prevention messaging.

9. The National AIDS Trust believes that the health inequalities agenda must look at the UK population in a variety of ways, including specific ethnicities, sexual orientation and residency status, as to better capture the various forms of inequality that exist.

⁴²⁹ Department of Health (2007) *The Operating Framework for the NHS in England: 2008–09*, www.dh.gov.uk/prod_consum_dh/idcplg?IdcService=GET_FILE&dID=156172&Rendition=Web.

⁴³⁰ Department of Health (2002) *Priorities and Planning Framework for 2003–06—Improvement, expansion and reform: the next three years*, www.dh.gov.uk/prod_consum_dh/idcplg?IdcService=GET_FILE&dID=10880&Rendition=Web;

Department of Health (2004) *National Standards, Local Health: Health and social care standards and planning framework 2005–06—2007–08*, http://www.dh.gov.uk/prod_consum_dh/idcplg?IdcService=GET_FILE&dID=7148&Rendition=Web;

Department of Health (2006) *The NHS in England: Operating framework for 2007–08*, http://www.dh.gov.uk/prod_consum_dh/idcplg?IdcService=GET_FILE&dID=115714&Rendition=Web.

⁴³¹ Further information from the Department of Health can be found at www.dh.gov.uk/en/Policyandguidance/International/EuropeanUnion/EUpresidency2005/DH_4114083.

⁴³² Shaw *et al* (2005) “Health inequalities and New Labour: How the promises compare to real progress,” *British Medical Journal*, 330: 1016–1021.

⁴³³ *Ibid.*

⁴³⁴ Elford *et al* (2007) “In the era of HAART how many people living with HIV are employed?” *British HIV Association Spring Conference*, Abstract P122.

⁴³⁵ National AIDS Trust (2007) *Poverty and HIV: Findings from the Crusaid Hardship Fund 2006*, www.nat.org.uk/document/207.

⁴³⁶ Cook *et al* (2007) *Ten Years of Monitoring HIV & AIDS in the North West of England*, http://www.nwpho.org.uk/10yearhiv/HIV_10years.pdf.

⁴³⁷ Confidential Enquiry into Maternal and Child Health (2007) *Saving Mothers’ Lives 2003–2005*, <http://www.cemach.org.uk/getattachment/ee9ca316-2a9a-4de6-9d48-ecaf5716e2b4/Why-Mothers-Die-2000-2002.aspx>.

UNEQUAL BURDENS OF ILL HEALTH AROUND LONG-TERM CONDITIONS

10. The current agenda to reduce health inequalities does not appear to adequately examine the kinds of health conditions most closely associated with inequalities. A PSA which focuses on infant mortality and life expectancy at birth may not catalyse effective consideration of unequal burdens of ill health around long-term conditions, such as HIV, which nevertheless involve significant morbidity.

11. In the UK, with the widespread availability and uptake of antiretroviral drugs among those who need them, HIV positive individuals are able to live long, healthy lives. HIV is now a chronic, manageable condition for many, and there has been a dramatic increase in life expectancy.

12. However, underlying factors like poverty, employment, housing, education and HIV-related stigma and discrimination affect people's long-term chances of staying well. Poverty is a principal source of ill health, particularly for those living with HIV, as health can be undermined by poor living conditions, below standard levels of support and a sense of powerlessness.⁴³⁸

13. Accepting that the PSA target will be with us until its timeline is completed, the National AIDS Trust believes that the DH should look at how to incentivise a more inclusive consideration of health inequalities within local PCTs and nationally, so that the wider social determinants of health and those that cause health inequalities are also examined. This will rely on strong and effective partnership across Government agencies, local authorities, community organisations and other key stakeholders.

STRUCTURAL CAUSES OF HEALTH INEQUALITIES WITHIN THE NHS

14. There can also be structural causes of health inequalities within the NHS. The most significant of these is the denial of free NHS care to refused asylum seekers and other undocumented migrants. To charge the, often, destitute for their care is deterring vulnerable people from continuing to access the vital treatment they need, with possibly fatal results and serious consequences for public health. There is increasing evidence that these regulations, potentially affecting up to half a million people not entitled to free NHS care, are causing harm.⁴³⁹

15. Denying free NHS care to certain vulnerable communities is a key concern previously raised by the Health Committee in its report *New Developments in Sexual Health and HIV/AIDS Policy*.⁴⁴⁰ Who should be allowed into the UK and who should be removed is an important policy issue, but one which should be treated separately from healthcare provision. If people are living in the UK, there are fundamental human rights, community cohesion and public health reasons why they should be able to access the care they need.

16. The National AIDS Trust asks the Health Committee to reaffirm its recommendations on charging as outlined in its *New Developments* report, to end the discrimination against people with HIV in sexual health services, ensuring free treatment for all. This must be one of the DH's primary concerns, providing free treatment for all to protect public health.

17. In addition, the National AIDS Trust believes that doctors are missing valuable opportunities to diagnose HIV in some vulnerable groups who are disproportionately affected by health inequalities. It is estimated that around one-third of those with HIV infection in the UK have yet to be diagnosed, many of whom are from black African communities, even though they are using primary care services. As HIV-related mortality is greater in those who are diagnosed late, early diagnosis is critically important.

18. While much of the treatment of HIV infection is specialised, the National AIDS Trust believes that the DH should look at how to scale up the important role GPs and primary care teams can play in the prevention, diagnosis and management of HIV infection.

PRISON HEALTH

19. The National AIDS Trust also believes that effective healthcare in prisons is an important public health opportunity to reach often severely marginalised sections of society. For example, a substantial majority of injecting drug users (IDUs) immunised against hepatitis B have been immunised in prison. The Government is also committed to the principle of equivalent healthcare in prison to that available in the community. However, from the HIV perspective, there are two glaring instances of unequal healthcare provision—the denial of needle exchange for IDUs in UK prisons, and the inadequate access to condoms in prisons (apart from Scotland, where condom vending machines have recently been approved).

20. The National AIDS Trust recommends that the Health Committee identify prison healthcare as a key opportunity and intervention to address health inequalities. In particular, prisons should support safer sex and safer injecting practices, both within prison and for the future life after custody, and provide accessibly clean needles and condoms to those who need them.

⁴³⁸ National AIDS Trust (2007) *Poverty and HIV: Findings from the Crusaid Hardship Fund 2006*, www.nat.org.uk/document/207.

⁴³⁹ Examples from the National AIDS Trust of charging can be found at www.nat.org.uk/document/336.

⁴⁴⁰ House of Commons Health Select Committee (2005) *New Developments in Sexual Health and HIV/AIDS Policy*.

CONCLUSION

The National AIDS Trust commends the Government for putting the reduction of health inequalities high on the NHS agenda. However, the National AIDS Trust believes that the DH should take a wider approach by considering how inequality is assessed, the unequal burdens of ill health around long-term conditions, structural causes within the NHS of health inequalities and prison health. This will allow the NHS to develop the holistic approach needed to effectively tackle health inequalities.

National AIDS Trust

January 2008

Memorandum by the Royal College of Nursing (HI 56)

HEALTH INEQUALITIES

1.0 EXECUTIVE SUMMARY

- The RCN welcomes the Government's announcement that extra funding would be targeted at reducing health inequalities. However, further progress is still to be made, not just in health, but in areas such as fiscal policy, employment, housing and education.
- Health services should be targeted towards those living in the most economically deprived areas, who are often the most difficult to reach and the most at risk of ill health.
- There is a shortfall of midwives, school nurses and health visitors across the UK and greater investment is needed in recruitment and retention of the nursing workforce.
- Those with learning disabilities or mental health problems remain a low priority in health and social care and dramatic improvements are needed to assist this sector of society.
- Those in employment who are financially self-sufficient are generally thought to experience better health and thus we are supportive of programmes such as the *Improving Lives and Choosing Health* which aim to support people in and returning to work.
- The RCN wishes to see more high quality developed general practice and community nursing services in areas which are currently underserved. We would also like more consideration to be given to how the Quality and Outcomes Framework (QOF) can be amended to increase the general practice incentives for providing services which aim to reduce health inequalities.
- We would like to see an English health promotional organisation re-instated that would be empowered to lead and co-ordinate targeted and influential campaigns.

2.0 INTRODUCTION

2.1 With a membership of over 390,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

2.2 Many of our members are community nurses, health visitors and midwives that work in the community and are vital to reaching those at most need. Nurses can play a vital role in promoting healthier lifestyles to patients and those nurses working in the community, in schools and with the most vulnerable groups of patients are well placed to promote the public health agenda and tackle health inequalities.

2.3 The RCN welcomes the opportunity to make a written submission to the inquiry of the Health Select Committee.

3.0 *The extent to which the NHS can contribute to reducing health inequalities, given that many of the causes of inequalities relate to other policy areas eg taxation, employment, housing, education and local government.*

3.1 The link between health inequalities and social inequalities is well known and accepted, with a marked difference in life expectancy and morbidity between socio-economic groups 1 and 5.⁴⁴¹ We recognise that whilst the health service alone cannot completely ameliorate health inequalities, high quality and accessible primary health care services can make a significant contribution to health improvement by tailoring services to those in greatest need. The Dawson Report (1920) called for improved primary health care and the

⁴⁴¹ Marmot, M., *Status Syndrome: How Your Social Standing Directly Affects Your Health* Bloomsbury: London (2004).

provision of health care centres in places where poor people lived in the belief that such services would greatly enhance the lives of these people. At the beginning of the NHS Nye Bevan highlighted how inadequately general practice was distributed and that it was the middle and upper classes that had far better access to a greater number of GPs than the more needy, less healthy people living in economically deprived areas.

3.2 It is a shocking fact that a similar situation exists today, which is why the RCN welcomed the recent announcement by the Secretary of State for Health that extra funding would be targeted towards areas of people with the poorest health. This aims to ensure that more general practice will be developed, thus helping to ease existing gaps in GP services.

3.3 However, this development must not diminish the many improvements which still need to be achieved in fiscal policy, secure and gainful employment, housing and education. All of these can bring benefits to lifestyle, life chances and health.

3.4 Targeting the health of disadvantaged groups is key to reducing health inequalities. Doing so can both assist in equalising access to services and equalising outcomes from health care interventions. The RCN believes in redesigning health services so that they focus on those most in need in order to compensate for poorer health status. Well developed general practice and community health workers, such as health visitors, school nurses and community midwives, can make a major contribution by reaching those people in greatest need.

3.5 The way in which local services are provided to the poorest people within the community needs consideration. Regional, economic and social disparities ensure that certain sections of society fail to participate in the decision making process to the detriment of their health needs.

3.6 If a reduction in health inequality is to be achieved, the role of children and families will be crucial. There is evidence to suggest that early years experiences can be a protective factor against social disadvantage in later life. For example, research has demonstrated significant improvement to the birth weight of babies born to low income mothers who received tailored support from midwives during pregnancy.⁴⁴² Pregnancy and the early years are a crucial period in which attention must be paid to supporting parents to nurture the physical and emotional wellbeing of their children. Educating and investing in families is the most effective way of empowering people to take control of their own health, and both midwives and health visitors are the professionals best placed to provide such support. However there is a shortfall of midwives and health visitors across the UK and those who are practicing face numerous workload and time pressures.

3.7 People with learning disabilities remain a low priority in health and social care. Following the "Treat me right" campaign by Mencap in 2004 little has improved for this group of people in our society. People with learning disabilities continue to die younger than others and we believe this is avoidable.⁴⁴³ The Department of Health's Learning Disability Taskforce Annual Report 2006-07 reported that poor progress had been made in respect of health, housing and employment for such people.

3.8 It is recognised that people with severe and enduring mental illness have poorer physical health outcomes than those who do not. While the causes of this are multi-factorial; such as the use of anti psychotic medication, lifestyle, social exclusion and poor interactions with primary health care professionals, the interventions needed to improve this situation are more simple. Good access to primary health care and health screening provided in a manner which is sensitive to client need is effective and should be more widely spread. Nursing interventions such as the RCN accredited "Well Being Programme" has demonstrated how well-prepared and supported nurses can help people adapt their lifestyles and enjoy better health.

3.9 A study of refugee and asylum seeking women in 2002 reported that of those interviewed fifty-six per cent suffered from depression, barely half had access to interpreters when visiting their doctor and only seventeen per cent described their English as good or fluent.⁴⁴⁴ The RCN is concerned that difficulty with communication and inadequate translation services could lead to neglect or inappropriate treatment.

3.10 It is generally accepted that those people in work who experience relatively secure and well paid employment and are financially self sufficient enjoy a better standard of health and wellbeing than those who are unemployed. The *Health, Work and Wellbeing* strategy builds on the work of *Improving Lives and Choosing Health* which aim to support people in and returning to work. The workplace can be therapeutic and health enhancing, therefore improving the nation's health and reducing the number of socially excluded.

3.11 The RCN supports the strategy recommending the provision of professional advice and guidance on work related health issues to those of working age via a range of stakeholders including the occupational health, primary care and mental health sectors. We acknowledge that this is a long-term strategy and a change of culture is required within health care and society. Work and unemployment are critical to reducing health inequalities and deserve greater attention.

⁴⁴² Oakley, A. *et al*, "Social Support and Pregnancy Outcome" *British Journal of Obstetrics and Gynaecology*, 97 (1990).

⁴⁴³ Mencap, "Death by indifference" (2007).

⁴⁴⁴ Dumper, Hildergard, *Is it safe here? Refugee women's experiences in the UK*, RefugeeAction: London (www.refugee-action.org.uk/information/documents/researchreport.pdf), 2002

3.12 It appears that age is also a determinant of health inequality. 1.8 million pensioners live in poverty, two-thirds of whom are women. Seventeen per cent of all pensioners and thirty-two per cent of older people from black and ethnic minorities live in poverty.⁴⁴⁵ The Government's annual report "Opportunity for All" states "it is essential that we continue to tackle poverty among older people". However, it is clear some groups of older people are more at risk from poverty, and thus ill health, than others.

3.13 The RCN welcomes the extra allocation of funds to spearhead PCTs. However, we wish to highlight our concerns over the PCTs which fail to attract extra funds despite their poor public health records. It would be preferable to have a gradient approach, thus ensuring that PCTs with poor public health records currently falling outside the margins necessary to receive funding would still obtain some financial support.

4.0 The distribution and quality of GP services and their influence on health inequalities, including how the Quality and Outcomes Framework and Practice-based Commissioning might be used to improve the quality and distribution of GP services to reduce health inequalities.

4.1 The RCN wishes to see more high quality developed general practice and community nursing services in areas which are currently underserved. We would also like more consideration to be given to how the Quality and Outcomes Framework (QOF) can be amended to increase the general practice incentives for providing services which aim to reduce health inequalities. The QOF is an excellent way of managing long-term conditions but in its current form does little to encourage people to attend their local practice before they begin to feel the effects of chronic disease.

4.2 General practice, with its registered list, is an ideal setting for promoting good health to the least healthy thereby improving quality of life and increasing life expectancy. However, the registered list can not be solely relied upon as it does not include the homeless or asylum seekers. We would urge PCTs and practice-based commissioners to expand the community nurse workforce and concentrate community health services in areas known to have large numbers of people who smoke, are overweight or inactive. The RCN also looks forward to the publication in late 2008 of the King's Fund report "Kicking Bad Habits: How can the NHS help us become healthier?" which will look at the interventions that are effective in encouraging healthy behaviour and the way in which the NHS can help people become healthier.

4.3 There is huge variation around the country regarding the understanding that GPs have of learning disabilities. There are some very good examples of practice but these are not widespread. In July 2007 the Secretary of State for Health announced that an independent inquiry was to be established to look at access to healthcare for people with learning disabilities. The inquiry will look to identify the action needed to ensure adults and children with learning disabilities receive appropriate medical treatment in primary and secondary care and we look forward to receiving the results of this inquiry.

5.0 The effectiveness of public health services at reducing inequalities by targeting key causes such as smoking and obesity, including whether some public health interventions may lead to increases in health inequalities; and which interventions are most cost-effective.

5.1 The RCN welcomed the Government's ban on tobacco advertising and smoking in public places and we believe the resources devoted to smoking cessation will continue to have a positive impact. Too many young people start smoking and continue to smoke into adulthood, finding it difficult to break this addictive habit. Nicotine Replacement Therapy helps the addicted smoker quit, but a significant number do well with added personal and skilled support. Once again, it is generally found to be less advantaged people who continue to smoke and who require more support if their lifestyles are to improve.

5.2 Furthermore, obesity rates are higher amongst the least wealthy and a range of services are required to tackle this issue. The RCN supports the Food Standards Agency's position on the clear and simple labelling of food.

5.3 The RCN also supports initiatives to ensure women are well-informed about the health benefits associated with breastfeeding. Breastfeeding has been shown to reduce health inequalities, improve the health of the mother and child and be cost effective. The RCN is a member of the Breastfeeding Coalition and supports their manifesto pledge calling for the marketing of formula milk to be controlled to the marketing standards set by the World Health Organisation International Code and subsequent resolutions.⁴⁴⁶ Rates of breastfeeding remain lowest amongst the most economically deprived and action needs to be taken to promote breastfeeding to this sector of society and to limit the advertising of breast milk substitutes.

5.4 Nonetheless, the effectiveness of national large scale health promotion campaigns is variable. Health promotion messages tend to be taken up first by the more socially advantaged, but little is ever done to monitor the impact that health promotion strategies have on the health gap between rich and poor. Evidence shows that health promotion messages often have the dual impact of improving health but also widening health inequality. Monitoring the impact of health interventions is an important role for health services, not least because there may be additional and compensatory measures that could be introduced.

⁴⁴⁵ www.dwp.gov.uk/asd/tabtool.dwptabulation

⁴⁴⁶ www.breastfeedingmanifesto.org.uk

5.5 In Scotland, Northern Ireland and Wales health promotional activity is centrally co-ordinated through a dedicated organisation. However, in England health improvement campaigns are managed by commissioned organisations. As a result there is little evidence of how priorities are agreed, information distributed and professionals enabled to promote these campaigns. We would like to see an English health promotional organisation re-instated that would be empowered to lead and co-ordinate targeted campaigns.

6.0 *Whether specific interventions designed to tackle health inequalities, such as Sure Start and Health Action Zones, have proved effective and cost-effective.*

6.1 While the RCN supported the principle of Health Action Zones, nurses were concerned that their creation led to an increase in geographical health inequalities, since not all socially deprived areas were in a Health Action Zone and thus lacked the extra resources associated with this status. The RCN welcomes any direction from Government that encourages joint working between relevant departments and agencies.

6.2 Although the current evidence base for the Sure Start initiative is not conclusive, there is anecdotal evidence to suggest that these centres have been successful in assisting the most vulnerable children and parents in society. Health inequalities arise out of a complex range of factors and are generally the result of long-term effects that require a long-term programme. We hope that the Government's continued investment in Sure Start Children's Centres will assist in reducing these inequalities in access to health services whilst also widening social care support by encouraging and enabling nurse-led innovations.⁴⁴⁷

6.3 The RCN particularly welcomes the initiative, Nurse Family Partnerships, aimed at helping children living within vulnerable families and we look forward to supporting the specially trained health visitors and other nurses involved in this important work.

7.0 *The success of NHS organisations at co-ordinating activities with other organisations, for example local authorities, education and housing providers, to tackle inequalities; and what incentives can be provided to ensure these organisations improve care.*

7.1 The success of NHS organisations at coordinating activities with other organisations varies widely and it is considered that even where there is effective integration between organisations, relationships can suffer when finances are severely stretched. Despite organisational cultural challenges the RCN wishes to see cross-organisational incentives and levers in place. These incentives should be aimed at reducing health inequalities and improving the life chances of children.

7.2 Where more established Children's Trusts are in place we are beginning to see a joined up approach to addressing health issues by pooling finances and targeting services.

7.3 In learning disability services, shifting responsibility for the provision of care has led to increased marginalisation, both of service users and the practitioners who care for them. Where services have been provided through mental health trusts or through independent sector organisations, standards of commissioning are inadequate due to the lack of input from service users and learning disability practitioners into the commissioning process.

8.0 *The effectiveness of the Department of Health in co-ordinating policy with other government departments, in order to meet its Public Service Agreement targets for reducing inequalities.*

8.1 In order for health inequality targets to be met the gap in life expectancy between different social groups needs to be narrowed. This means moving towards health services for secondary prevention and effective treatment of coronary heart disease and cancer. Whilst we welcome the recent publication of the Cancer Reform Strategy⁴⁴⁸ there is still more to be done and public health statistics confirm that there remains a variation in health across the UK with some areas requiring targeted action.

8.2 Whilst the 2007 Department of Health report "Review of health inequalities infant mortality PSA target" shows that infant mortality rates are low, it also highlights the disparity between different social groups. Evidence shows that services need to be targeted at those most in need, particularly the most vulnerable, whilst also improving ways of working across organisations and sectors, such as welfare advice, housing and children's centres.

8.3 Local Area Agreements are important in meeting health inequality targets. These policies require local government to improve the health of local people, co-ordinate local service delivery and create strong partnerships with other stakeholder organisations. We support the joint appointments of Directors of Public Health and expect that these appointments will help to ensure that Local Area Agreements are implemented across health and local authorities. Despite these roles being relatively new we are confident that once they have been evaluated they will support greater cross-organisational working.

⁴⁴⁷ The Chatterbox initiative in Plymouth is an excellent example of a nurse-led innovation. The initiative was set-up by health visitors who identified a gap in services for young families who wanted to meet up for advice and support.

⁴⁴⁸ Department of Health, December 2007.

9.0 Whether the Government is likely to meet its Public Service Agreement targets in respect of health inequalities.

9.1 While the Health Profile of England 2007 showed progress in some areas towards reducing health inequalities it is clear that there are still significant improvements to be made. Regional health inequalities still exist, rates of obesity, diabetes and alcohol related hospital admissions are rising, deaths from chronic liver disease and cirrhosis have risen markedly, and despite declining teenage pregnancy rates, the UK also has the highest proportion of births to women under twenty compared to any other Western European countries.⁴⁴⁹ It is therefore unlikely that many of the Public Service Agreement targets set by the Department of Health will be met.

9.2 Rising obesity levels also appear to be prevalent amongst children as well as adults. Whilst we support efforts to improve information to consumers about the food that they purchase, more needs to be done with industry to improve dietary information, reduce saturated fats and sugars in food and address the advertising of fast food, snacks and sweet drinks. In addition to this, more emphasis should be placed on actively encouraging exercise by providing safe play facilities and open space in communities.

January 2008

Memorandum by the Royal Society of Health, the Royal Institute of Public Health, and the National NGO Forum (HI 57)

HEALTH INEQUALITIES

1. BACKGROUND

1.1 The Royal Society of Health (RSH) and the Royal Institute of Public Health (RIPH) were established during the mid-Victorian era to promote and protect public health. The two organisations are experiencing a major resurgence at present and will be merging during 2008. They are both Registered Charities.

1.2 The combined membership of the RSH and RIPH is almost 7,000, comprising practitioners and professionals from all areas of public health. Both organisations are recognised Awarding Bodies by the Qualifications and Curriculum Authority (QCA) and over 100,000 individuals qualify every year through their networks of training institutions.

1.3 Established in 1999, the NGO Forum has been managed by the RSH since April 2006 under a contract with the Department of Health (DH). The Forum includes approximately 100 national NGOs, comprising of the major health charities (eg Diabetes UK, British Heart Foundation, etc.), professional associations (eg Faculty of Public Health, Chartered Institute of Environmental Health), consumer bodies (eg Which), advocacy organisations (eg UK Public Health Association), NGOs who create practical changes to the built environment (eg Sustrans).

2. INTRODUCTION

2.1 All three organisations have a strong interest in inequalities in health. The NGO Forum relates to the DH through the "Health Inequalities" Branch. Members of the Forum are committed to reducing health inequalities.

2.2 The NGO Forum, with support from the Royal Society of Health, is in the process of establishing a National NGO Plan for Health. The expectation is that this will be launched in approximately twelve months time and will address health inequalities. Many Forum members work closely with NHS bodies and, indeed, receive funding from the DH or NHS to take forward work designed to reduce inequalities in health. The work of the "Third Sector" is directly relevant, therefore, when reviewing the contribution made by the NHS on this issue.

2.3 The RSH receives funding from the DH to take forward development work with NHS organisations and practitioners engaged in health promotion. In addition, the RIPH has a contract from the DH to provide qualifications for health trainers, many of whom work in or with NHS organisations.

2.4 All three organisations endorse the Select Committee's view that inequalities in health are determined to a large extent by non-NHS factors, such as housing, fiscal policy, education, and environmental issues. This submission, however, will concentrate on the role of the NHS and the interrelationship between the NHS and the "Third Sector".

2.5 The RSH, RIPH and NGO Forum support the principles, priorities and actions set out in "*Health Inequalities: Programme for Action*" (DH, June 2003)

⁴⁴⁹ Department of Health, October 2007.

The Actions likely to have greatest impact:

- improvements in early years support for children and families
- improved social housing and reduced fuel poverty among vulnerable populations
- improved educational attainment and skills development among disadvantaged populations
- improved access to public services in disadvantaged communities in urban and rural areas, and
- reduced unemployment, and improved income among the poorest
- reducing smoking in manual social groups
- preventing and managing other risks for coronary heart disease and cancer such as poor diet and obesity, physical inactivity and hypertension through effective primary care and public health
- improving housing quality by tackling cold and dampness, and reducing accidents at home and on the road

To close the gap in infant mortality, key short-term interventions include:

- improving the quality and accessibility of antenatal care and early years support in disadvantaged areas
 - reducing smoking and improving nutrition in pregnancy and early years
 - preventing teenage pregnancy and supporting teenage parents
 - improving housing conditions for children in disadvantaged areas
- Extract from “*Health Inequalities: Programme for Action*”.

The RSH, RIPH and NGO Forum would welcome an opportunity to provide oral evidence to expand on this succinct submission.

3. POTENTIAL FOR THE NHS TO MAKE AN IMPACT ON HEALTH INEQUALITIES

3.1 Although the fundamental determinants of health have by far and away the greatest impact on health inequalities, there is an important role for the NHS to play. This role concerns:

- Needs assessment and public engagement
- Access to NHS services;
- A leadership role for PCTs and Strategic Health Authorities in stimulating partnerships that address the wider determinants of health and inequalities;
- The NHS commissioning function;
- PCTs acting as the catalyst for financial investment in deprived areas;
- The role of the NHS as a provider of technical expertise in areas such as “health impact assessment”.
- Sustainable development—the NHS as a model of good practice

3.2 Equity of access: The NHS frequently refers to “hard to reach” groups, usually those at greatest risk of ill health. In making such statements, planners are looking down the “wrong end of the telescope”. From the perspective of those individuals at greatest disadvantage, we are referring to “hard to reach services”. Whether planning health promotion, prevention, or health care, services should always be developed to meet the needs of the local community, rather than expecting the community to meet the needs (and constraints) of the services. Equity of access is a starting point for reducing inequalities in health.

3.3 Community assets: All communities have assets as well as needs. Even where there is a comprehensive needs assessment, it is rare for local community assets to be mapped as a resource for better health. Assets can include information networks, opinion formers, local leaders, skills, community organisations, and social networks. We encourage PCTs to undertake an assessment of community health assets, as well as needs.

3.4 NGOs and local community groups are often best placed to deliver health promotion support to disadvantaged communities, be it increasing physical activity or improving diets. They do not have the “stigma” sometimes associated with formal public sector service provision. NGOs tend to adopt more informal approaches, based upon the natural organisational and communication structures inherent to the community, and are perceived as being less “authoritarian”. The NHS has a key role in working with local communities to identify their health needs and aspirations, and subsequently commissioning the services (whether NHS managed or not) which best meet those needs. The NHS does not always take full advantage of the expertise of NGOs, nor develop in-depth and mutually-beneficial partnerships with them.

3.5 User and community engagement: There are tried and tested ways of community engagement in setting local NHS priorities and in designing local service provision. However many NHS bodies fail to engage successfully with their users and lack expertise in their involvement. The role that volunteering has in improving health is under utilised within the NHS.

3.6 Strategic partnerships: The overall resources available in a community to tackle health inequalities extend well beyond the NHS. NHS organisations have a responsibility to build “strategic partnerships” in order to make the best use of the community resources available. The NHS has a pivotal role as convenor and facilitator in relation to health inequalities, in partnership with the local authority. In order to fulfil this catalytic role regionally and locally, SHAs and PCTs need to develop the necessary capacity and skills required to build effective partnerships. Feedback from local organisations and practitioners suggests that many, perhaps most, strategic partnerships tend to be superficial, rather than truly productive. This is reinforced by the *2006 National Evaluation of LSPs* (Department of Communities and Local Government, June 2007), which indicated that LSPs are still predominantly concerned with process, structures and protocols. Key partners for the NHS include local authorities, NGOs, regional and local media, and higher education institutions.

3.7 The “commissioning” function of PCTs is usually viewed as being largely concerned with purchasing secondary and tertiary care services. Much more emphasis should be placed on the commissioning of health promotion and disease prevention initiatives, specifically directed at the determinants of health in the most disadvantaged communities. For example, the NHS is a major purchaser of food and could influence the food supply chain by using its economic power to insist upon “healthy” specifications and locally-sourced food. The public sector could fundamentally alter the food chain from agriculture through manufacturing, processing, retailing, catering and marketing, by exercising its economic strength in the market place.

3.8 Financial investment: NHS organisations are major investors of capital and major employers. In reaching investment decisions, little or no account is taken about how to achieve the greatest health gain. To give an example, decisions about where to site support services, such as laundry, are invariably taken on the basis of transport logistics rather than the potential for providing jobs in areas of significant unemployment. The potential for health gain by targeting investment to the areas of greatest development need should be given much more emphasis. This will entail a “health impact assessment”, which considers the overall health benefit (or cost) of each option.

3.9 Health impact assessment: Decisions are frequently taken by the NHS and local authorities without a full understanding of their wider health impact. The NHS is best placed to assist in providing the necessary technical expertise to aid not only decision-making within the NHS, but in other public bodies as well.

3.10 Climate change/sustainable development: There is not the slightest doubt in the eyes of the vast majority of scientists that climate change is real and will have an enormous impact on health over the coming decades. The least well-off suffer most from any major environmental challenge to health. Climate change and, by definition, sustainable development are “inequalities” issues. As such, the NHS should be at the forefront in adopting carbon emission limiting policies, even if this requires an initial injection of capital resources. In due course, such investment would reap a dividend in reduced recurring expenditure. Transport and energy policy, commissioning criteria, and purchasing specifications should all reflect the NHS’ commitment to good practice.

3.11 Dental disease: It is worth adding that dental disease is also a function of disadvantage, poor people suffering more than the better-off. NHS bodies should ensure that they have a clear policy in support of fluoridation.

4. HEALTH DISTRIBUTION ACROSS THE COMMUNITY—WHERE TO FOCUS?

4.1 Policies to tackle health inequalities often target the 10% most disadvantaged in the community. Although they are most at risk of poor health, they are numerically small in terms of the overall size of the population. Moreover, identifying the 10% “outliers”, without addressing other groups in society, ignores the whole process of social influences on health.

4.2 A case can be made for targeting a much larger group, say the 35–40% of the population above the 10% most at risk, with additional, intensive action. This would have the dual advantage of taking into account some of the wider social pressures on the health of the worst-off and also address a much larger group of individuals, who are relatively disadvantaged compared to the mean. The numerical impact of this combined health inequalities strategy could well be much more noticeable than merely focussing on the 10% of the population at greatest disadvantage.

5. CAPACITY, CAPABILITY AND WORKFORCE DEVELOPMENT

5.1 The ability of the NHS to fulfil its potential in reducing inequalities is dependent on having the right number of people with the right skills deployed in the right way. Feedback from public health practitioners indicates that England has a dearth of appropriately skilled individuals in post. The most recent reorganisation of the NHS appears to have decimated what was already a fragile infrastructure in many PCTs. It is ironic this has occurred just as there is a growing recognition of the importance of health promotion and prevention nationally.

5.2 In his report to the Prime Minister in 2004, Derek Wanless identified the problems associated with capacity and restructuring:

Much of the workload in the health services in achieving local objectives will fall on PCTs. They are relatively new and small bodies and they have a crucial role in ensuring the NHS delivers, particularly in commissioning and in driving behaviour changes in primary care. Each has a Director of Public Health and this is spreading existing resources very thinly, although there is a welcome move to broaden the skill base by introducing non-medical Specialists. PCTs will be vital in making the new primary care contracts work to best effect, including in public health. Given the newness of the structure and that repeated restructuring has tended to weaken the NHS over decades, structural change is not recommended but where it seems locally that the best way forward is to combine PCTs' forces to tackle public health that should not be discouraged.

—Extract from Wanless report, Feb. 2004.

5.3 Judging from reports received by the national bodies, the enlarged PCTs appear to have shed capacity rather than improved it. As the Chief Medical Officer has said (Annual Report, 2006), recent public health investment is in line with the “slow uptake” rather than fully-engaged scenarios. The view of the RSH, RIPH, and National NGO Forum is that it is wholly unrealistic to expect any significant impact on health inequalities with the current levels of PCT investment in public health and health promotion capacity.

5.4 Following publication of the Second Wanless Report (Feb. 2004), the Government made a welcome and strong commitment to public health and the reduction of health inequalities through the publication of “Choosing Health” (DH, Nov. 2004). This included specific “Choosing Health” funding for PCTs. However, the “Choosing Health” monies have been rolled into the overall funding for PCTs and most have deployed their funds to meet other needs. Sexual health and HIV/AIDS services could be examined to see the impact of this under investment. Waiting times and achieving financial balance are still the pre-eminent considerations. This is a major missed opportunity and should be redressed as a matter of urgency. Health inequalities must be given a much more prominent position in the performance management agenda. The RSH is currently piloting a national “Award Scheme” to recognise PCTs and other local organisations that meet a range of criteria, including financial investment and workforce development.

5.5 “Choosing Health” indicated that the NHS should embrace and capitalise on all the opportunities resulting from the numerous daily encounters people have with NHS.

- Make the most of the millions of encounters that the NHS has with people every week;
- Ensure that all NHS staff have training and support to embed health improvement in their day to day work with patients;

—Extract from “Choosing Health”.

This is not happening. Many NHS practitioners do not have the necessary training and skills. There has been a failure locally to “scale up”, as identified in the Wanless Report, a whole range of initiatives from Health Action Zones to the Expert Patients Programme. Investment is wasted when it is not of sufficient scale to produce health impact.

5.6 Some initiatives identified in “Choosing Health” have been taken forward, but are unlikely to be sustained. For example, the “Health Trainers” programme is showing early signs of success, not only in terms of reaching those individuals at higher than average risk of poor health, but also in releasing non-NHS resources. Some 1,500 health trainers are now in place, with several thousand more undergoing training. Our assessment is that we probably need between 50,000 and 100,000 health trainers to make real impact, but it now looks likely that the earmarked funding for the “Health Trainers” programme will come to an end during 2008. As indicated in the Wanless Report, success will be dependent on long term, sustained and targeted investment.

5.7 Each PCT should have a “Workforce Development Plan” that focuses on the organisation’s health inequalities objectives and the skills needed to achieve these. This should include all PCT staff, not just the specialised staff involved in planning and management, and it should also include the “wider public health workforce” in the community, who also need training and development. A “ladders and bridges” approach allows staff to improve their skills over time and according to changing community needs. Universities and NGOs can play an important role in both training needs assessment and in delivery.

5.8 The “Teaching Public Health Networks” have much to contribute in sharing good practice. We strongly recommend that support for the TPHNs should continue.

6. THE DEPARTMENT OF HEALTH

6.1 It would be remiss of us not to comment on recent changes at the Department of Health. In contrast with the situation locally, the DH has given greater emphasis to public health and inequalities, not least through a clear emphasis on workforce development.

6.2 The recent decision to highlight the importance of health inequalities through the cross Government role envisaged for one of the Deputy Chief Medical Officers is welcomed. So too is the intention to strengthen the DH public health commissioning function, which will enable the DH to have a more comprehensive

overview of the support required. Despite the emphasis on workforce development, DH efforts will have limited impact without a similar commitment to invest locally in public health, health promotion, and action to reduce health inequalities.

7. IN CONCLUSION

7.1 The NHS can enhance its impact by commissioning organisations such as NGOs and universities to undertake health inequalities work, where they have specialised expertise, and exercise its leadership role in strategic partnerships, especially with local authorities.

7.2 Success will not be achieved without a much greater investment in local public health capacity, including health promotion and community development.

7.3 NHS organisations should use their economic power to influence supply chains.

7.4 The NHS should use its capital funding and role as a major employer to invest for the greatest community health gain, taking the longer term view into account.

7.5 Services should be planned to meet the needs of communities rather than expecting disadvantaged groups to meet the needs and constraints of the NHS.

7.6 The NHS should provide specialised technical advice on issues such “health impact assessment”, “equity audit”, “needs assessment”, and “community development” to other public bodies.

7.7 In the longer term interests of health, NHS bodies should be a model of good practice when it comes to sustainable development.

7.8 The RSH, RIPH and the NGO Forum would welcome an opportunity to discuss these issues with the Health Select Committee and are happy to assist the Committee with its investigations.

January 2008

Annex

NGO Forum members submitting response to Health Inequalities Inquiry

1. Action for Blind People
2. African HIV Policy Network
3. Age Concern England
4. ASH (Action on Smoking and Health)
5. Association for the Study of Obesity
6. Association of Directors of Public Health
7. Association of Directors of Social Services
8. Asthma UK
9. Barnardo's
10. Black Health Agency
11. British Dental Association
12. British Dental Health Foundation
13. British Dietetic Association
14. British Flouridation Society
15. British Heart Foundation
16. British Medical Association
17. British Nutrition Foundation
18. Brook Centres
19. Cancer UK
20. Child Poverty Action Group
21. CIEH—Chartered Institute of Environmental Health
22. Clubs for Young People
23. Commission for Racial Equality
24. Community Action Network
25. Community Development Exchange
26. Community Health Involvement & Empowerment Forum
27. Consensus Action on Salt and Health (CASH)

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28. Consumers Association
 29. Continyou
 30. Council of Ethnic Minority Voluntary Sector Organisations (CEMVO)
 31. CSV
 32. Diabetes UK
 33. Drug Scope
 34. Equalities National Council
 35. Faculty of Public Health
 36. Faithworks
 37. Food Commission
 38. Forum for the Future
 39. FPA
 40. Homeless Link
 41. Institute of Rural Health
 42. JCWI—Joint Council for Welfare of Immigrants
 43. Lesbian & Gay Foundation
 44. Local Government Association
 45. Medical Foundation for AIDS & Sexual Health
 46. Meningitis Trust
 47. Men's Health Forum
 48. Mental Health Providers Forum
 49. MIND
 50. Muslim Council of Great Britain
 51. National Aids Trust
 52. National Children's Bureau
 53. National Healthy Living Alliance
 54. National Heart Forum
 55. National Council of One Parent Families
 56. NEA (National Energy Action)
 57. No Smoking Day
 58. NSPCC—National Society for Prevention of Cruelty to Children
 59. Nuffield Trust
 60. Nutrition Society
 61. Patient information Forum (PiF)
 62. Patients' Association
 63. Pharmacy HealthLink
 64. Royal College of General Practitioners
 65. Royal College of Midwives
 66. Royal College of Nursing
 67. Royal College Physicians
 68. Refugee Council
 69. RNID
 70. RoSPA—Royal Society for the Prevention of Accidents
 71. RPSGB—Royal Pharmaceutical Society of Great Britain
 72. SANDS (Stillbirth and Neonatal Death Society)
 73. Scarman Trust
 74. Save the Children Fund UK
 75. Society for Health Education & Promotion Specialists
 76. Society of Local Authority Chief Executives and Senior Managers

77. South Asian Health Foundation
 78. Stroke Association
 79. Students in Mind
 80. SUSTAIN (alliance for better food & farming)
 81. Sustrans
 82. The Kids' Cookery School
 83. Terence Higgins Trust
 84. The Obesity Awareness & Solutions Trust (TOAST)
 85. Trading Standards Institute
 86. UKPHA
 87. UNITE
 88. World Cancer Research Fund
 89. Womens' Institute
 90. YMCA England
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Memorandum by the Prostate Cancer Charter for Action (HI 58)

THE CONTRIBUTION OF THE NHS TO REDUCING HEALTH INEQUALITIES

1. INTRODUCTION

1.1 The Prostate Cancer Charter for Action is made up of 21 organisations from the voluntary and professional sector with a commitment to tackling prostate cancer.

1.2 There are a number of health inequalities which affect prostate cancer, including:

- Men of African descent are three times as likely to be diagnosed with prostate cancer than men from other backgrounds
- Awareness of the prostate and its function remains low amongst many groups
- Men continue to experience challenges in accessing primary care, with services often not being designed around their needs
- Too many patients are only diagnosed with prostate cancer once their cancer has spread, limiting treatment options and significantly compromising their chances of cure
- Men with prostate cancer continue to report a significantly worse experience of their treatment and care than patients with other common cancers

1.3 We therefore welcome the Health Select Committee's decision to hold an inquiry into health inequalities.

2. THE EXTENT TO WHICH THE NHS CAN CONTRIBUTE TO REDUCING HEALTH INEQUALITIES

2.1 Despite some progress in improving prostate cancer services over the past few years, much more needs to be done, particularly if inequalities in experience and outcome are to be addressed. We welcome the recent publication of the Cancer Reform Strategy, which includes a number of commitments which could help tackle inequalities. These initiatives need to be implemented as a matter of urgency.

2.2 The NHS does have an important role to play in reducing health inequalities. Whilst it is true that many of the causes of inequalities relate to other policy areas such as a patient's employment status, housing conditions or educational background, the NHS should function in a way so that these factors do not stand in the way of a person accessing timely and appropriate healthcare.

2.3 Of particular relevance to prostate cancer, the NHS has a role to play in reducing health inequalities by providing timely and relevant information about health issues, including disease symptoms and treatment choices. A man diagnosed with prostate cancer has to make many complicated decisions about his treatment and care, each with differing benefits and drawbacks. It is therefore vital that a man has access to standardised information and support as he makes choices about his treatment, letting him weigh up issues such as efficacy and quality of life. It is the role of the NHS to make sure that this information is available to prevent low levels of health literacy from widening health inequalities.

2.4 The provision of specialist nurses can also play an important role in reducing health inequalities by supporting men with prostate cancer in making difficult choices about their treatment and care. Access to a named specialist nurse is particularly important for prostate cancer patients who perhaps may require

support in coming to terms with living with cancer, or managing side effects of treatment such as incontinence or impotence. A recent report by the Prostate Cancer Charter for Action, *Because Men Matter—the case for clinical nurse specialists in prostate cancer*, found that significant geographical variation exists in the provision of urological cancer clinical nurse specialists and provision of such specialists lags behind that for patients with other forms of cancer. Clinical nurse specialists for men with prostate cancer have, on average, double the workload of newly diagnosed patients compared with breast cancer nurses.

2.5 Suggested recommendation—The NHS should invest immediately in improving the provision of urological cancer clinical nurse specialists. This would mean that men with prostate cancer have access to information and advice on their treatment options, as well as greater support from experienced professionals in their battle against prostate cancer. As a first step, the NHS should aim to bring provision for urological cancer up to the same rate of newly diagnosed cases per Clinical Nurse Specialist as currently exists for breast cancer. This would require an additional 260 Whole Time Equivalent Clinical Nurse Specialists for urological cancers, more than doubling the current workforce.

3. THE DISTRIBUTION AND QUALITY OF GP SERVICES AND THEIR INFLUENCE ON HEALTH INEQUALITIES

3.1 Both the accessibility and quality of GP services can have a significant impact on inequalities in prostate cancer.

3.2 Accessibility

Men and women have very different healthcare needs and therefore require different kinds of health services. Women are more likely to visit traditional primary care services such as the GP surgery because of issues such as reproductive health or childcare. Indeed statistics about GP usage confirm that men are far less likely to visit their doctor—on average, males visit an NHS GP four times a year while women visit six times a year.

3.3 This difference in access produces an opportunity cost—there are fewer opportunities for healthcare professionals to identify a variety of health problems, including prostate cancer, in men at an earlier stage where a greater range of treatment options is available.

3.4 We welcome the positive reference in the Cancer Reform Strategy to community based prostate health clinics as a potential model for enhancing the primary care support available to men with prostate health problems. As part of this model, decision advisers would help men at the following points in the pathway:

- Men without symptoms considering having a PSA test or equivalent
- Men with urinary or other potential symptoms of prostate cancer
- Men considering having a biopsy for prostate cancer following a PSA test
- Men diagnosed with benign prostate disease

3.5 Decision advisers could be clinical nurse specialists (CNSs) on a dedicated or outreach basis, GPs with a special interest in prostate cancer, community based specialist urologists or other appropriately trained practitioners. Access to prostate health clinics would be via GP referral or direct access for men concerned about their prostate health.

3.6 Improved support for men in making decisions about further investigation or treatment would not be a form of rationing, but rather a way of ensuring that men have the best possible information and support when making difficult decisions. Improved support for men will ensure that more appropriate referrals for biopsy or further care will be made, reducing unnecessary interventions and complications, saving significant levels of NHS resources.

3.7 Suggested recommendation—The community-based prostate health clinic model should be piloted and evaluated. Clear guidelines will need to be developed for community based prostate health clinics so that they address, for example, the difficulties men currently have in accessing traditional primary care services and so do not worsen health inequalities in this area. Experts in prostate cancer and wider men's health issues, including charities and patient groups, must be consulted as part of this process.

3.8 Further use should also be made of the workplace as a potential venue for health information and advice. Research by the Men's Health Forum amongst others indicates that men welcome the provision of health information and services in this setting. Such an approach can also avoid some of the access issues which can result from many primary care services only being open during normal working hours.

4. QUALITY

4.1 Feedback suggests that there are also variations in the quality of advice and support given in primary care on issues relating to prostate cancer, notably those relating to PSA testing and diagnosis. Introducing models such as community-based prostate health clinics could help address this, but it will also be important to update and improve the support available to GPs.

4.2 The Prostate Cancer Risk Management Programme (PCRMP) is intended to support men without symptoms of prostate cancer in making an informed choice about whether to have a PSA test. We support the principle of informed choice but believe that the PCRMP is in urgent need of updating to reflect developments in the evidence base and experience gained from its use in practice. Furthermore, a Department of Health-funded evaluation has found that there are significant variations in the way in which GPs use the PCRMP, so potentially leading to inequalities in the advice given to men who are concerned about prostate cancer.

4.3 The Department of Health has committed itself to updating the PCRMP on several occasions over the past few years, but there have been extensive delays in this process.

4.4 Suggested recommendation—The PCRMP should be updated urgently and launched no later than April 2008. Patients and men who have not been affected by prostate cancer should be involved in this process. Particular attention should be given to encouraging GPs to make use of the revised PCRMP and assessing its impact on reducing variations in the advice given to men.

5. THE EFFECTIVENESS OF PUBLIC HEALTH INTERVENTIONS

5.1 Public awareness can play an important role in tackling health inequalities, ensuring that everyone is informed about signs, symptoms and risk factors of ill-health. This is true of prostate cancer, where men need to be aware of their prostate, its function, what can go wrong with it and where they can seek help and advice.

5.2 Unfortunately the evidence base on what works in raising awareness remains relatively thin, particularly amongst men. With this in mind, signatories to the Charter co-funded with the Department of Health a pilot awareness programme on the prostate and its function which took place in Coventry. The pilot demonstrated both the importance of carefully targeting health messages to reflect cultural sensitivities and that community-based approaches to awareness raising can be effective. It also showed that further research work is necessary to test and evaluate different approaches to raising awareness. These findings helped to inform the Department of Health's decision to launch a National Awareness and Early Detection Initiative (NAEDI) is part of the Cancer Reform Strategy. We wholeheartedly welcome this initiative and call on the Department of Health to ensure that prostate cancer is an early focus for it.

5.3 Suggested recommendation—The NAEDI should be supported by significant levels of funding to test and evaluate different approaches to raising awareness and encouraging early detection of cancer. Further prostate cancer pilots should be initiated within this. The findings of this work should be disseminated to all those with an interest in raising awareness.

January 2008

Memorandum by Age Concern (HI 59)

HEALTH INEQUALITIES

SUMMARY

The NHS can contribute both directly and indirectly to reducing health inequalities by increasing staff awareness and knowledge of the issues. There are practical steps the NHS can take in tackling health inequalities, often by working more closely with other organisations. A key aspect of health inequalities for older people remains age discrimination in service provision. Age equality must become a cornerstone of the planning and provision of services, and there must be equity of access to information and support.

1. INTRODUCTION

1.1 Age Concern welcomes the opportunity to submit evidence to the House of Commons Health Committee Inquiry into the contribution of the NHS to reducing health inequalities.

1.2 Age Concern England (the National Council on Ageing) brings together Age Concern organisations working at a local level and 100 national bodies, including charities, professional bodies and representational groups with an interest in older people and ageing issues. Through our national information line, which receives 170,000 telephone and postal enquiries a year, and the information services offered by local Age Concern organisations, we are in day to day contact with older people and their concerns.

2. ADDRESSING SOCIAL DETERMINANTS OF HEALTH

2.1 NHS practice can contribute directly to preventing disadvantage. For example, worklessness is a major risk factor for social disadvantage. Older workers who are absent from work for health reasons for even a relatively short time risk never working again. Active treatment with rehabilitation in mind can reduce the risk of social—and, in the longer term, health—disadvantage.

2.2 As poverty is associated with poorer health, the NHS can play a very important role in promoting full take-up of benefit entitlements, particularly among older and disabled people and their carers. The most recent Department for Work and Pensions estimates indicate that up to £4.6 billion of means-tested benefits go unclaimed by older people each year and many more miss out on vital help towards disability costs such as Attendance Allowance and Disability Living Allowance. Those who miss out on these benefits are often older and frailer members of society. They are however more likely to be in contact with NHS services, particularly in primary care, which provides an ideal opportunity to provide information and advice about benefits.

There are existing examples of good co-operative working in this area:

- The Health Advice Benefit Initiative Team (HABIT) is a service provided by Age Concern Liverpool in collaboration with primary health care teams and other agencies. A letter from their GP and Age Concern Liverpool is sent to patients, encouraging them to contact HABIT. They can then be seen in their own home, at their health centre or doctor's surgery, at Age Concern Liverpool's city centre offices or at one of the local outreach sessions.⁴⁵⁰
- The Newham GP Advice Project, managed by Newham Council Social Regeneration Unit, bases welfare advisers in GP practices. An evaluation of the service in 2006 concluded that it freed up GP's time to concentrate on medical matters and improved people's health and well-being through addressing poverty and social welfare issues.⁴⁵¹

2.3 Wider adoption of good practice in this area would result in older people receiving an increased income which is likely to have a positive impact on their quality of life, health and wellbeing.

2.4 Age Concern recommends that NHS staff are made aware of the social determinants of health and how their practice can contribute to reducing health disadvantage. They do not need to be experts in the benefits system but they should have an awareness of potential entitlements and links to advice agencies to which they can refer patients. The Department of Health and Primary Care Trusts should encourage the provision of benefits advice sessions in GP practices and other primary care settings, working with other agencies.

2.5 Age Concern recommends that the Department of Health and the Department for Work and Pensions should work together to identify best practice and disseminate findings widely.

3. GP SERVICES

3.1 Some groups of older people with particularly significant health needs currently receive insufficient support from GP services:

- 3.1.1 Older carers often experience poorer health than their peers.⁴⁵² Due to the pressure of caring responsibilities, they may neglect their own health needs, and it may be difficult for them to come to a surgery for an appointment as they may be unable to leave the person they are caring for. Organising a visit to the surgery for the person they are caring for can be equally difficult and stressful. Carers should be able to have a home visit if required. GP practices should take into consideration the social circumstances of carings in deciding whether to undertake a home visit.
- 3.1.2 While people living in care home are entitled to register with a GP practice and therefore receive core general medical services, there has been a failure to address nationally the need for a system to provide clinical leadership and support for care homes from the NHS. A variety of systems is in place with some homes paying a "retainer" fee to GPs for additional services, the cost of which is sometimes passed on to residents in care home fees. People living in care homes by definition have greater health needs than other members of the community and the coordination and planning of their health care needs to be led by the NHS.
- 3.1.3 Depression in later life is very common with about a quarter of people over 65 showing signs of this condition.⁴⁵³ However, depression is not an inevitable aspect of ageing and can be treated. The UK Inquiry into Mental Health and Wellbeing in Later Life highlighted that this condition is under-diagnosed and under-treated. It is estimated that only about 15% of all older people with depression are diagnosed and receive treatment.⁴⁵⁴

⁴⁵⁰ Health Advice Benefit Initiative Team (HABIT): <http://www.ageconcernliverpool.org.uk/index.php?page=habit>

⁴⁵¹ Newham GP Advice Project: <http://sru.newham.gov.uk/PDFs/GP%20Project%20ImpAss.pdf>

⁴⁵² Social Policy Research Unit, Univ. of York, *Hearts and Minds. The health effects of caring*, 2004.

⁴⁵³ Age Concern, *Improving services and support older people with mental health problems: Second report from the UK Inquiry into Mental Health and Wellbeing in Later Life*, 2007: www.mhilli.org

⁴⁵⁴ *Ibid.*

3.2 Age Concern recommends that Department of Health supports and incentivises GP services to:

- Improve access to carers;
- provide a clinical lead for care homes; and
- diagnose and treat depression in older people when warranted.

4. PUBLIC HEALTH SERVICES

4.1 The majority of chronic illnesses affecting the lives of older people can be either prevented or postponed, mainly through the adoption of healthy lifestyles. Yet public health initiatives are often designed to exclude older people, in spite of strong evidence that they people could benefit.

4.2 Older people stand to benefit greatly from healthy eating, keeping physically active, and sensible drinking, not just to extend life expectancy but to increase wellbeing and independence.

4.3 The promotion of physical activity is often linked with sports, for example with the 2012 London Olympics, rather than incorporating activity into people's daily lives. Such association does not necessarily motivate older people.

4.4 The fact that an estimated 10% of people over the age of 65 living in the community suffer from malnutrition⁴⁵⁵ is often overshadowed by the efforts to combat the obesity epidemic.

4.5 The current national alcohol strategy does not mention drinking in later life.⁴⁵⁶

4.6 Programmes to promoted good mental health rarely include older people and are separate from programmes to improve good physical health, in spite of the interplay between the two.

4.7 The demand to demonstrate cost-effectiveness mitigates against investing in initiatives to improve health of older people as they by definition will have fewer years of benefit.

4.8 Age Concern recommends that all mental and physical health promotion strategies should be desinged to include older people while acknowledging that different initiatives are likely to be effective for different age groups.

5. AGE EQUALITY

5.1 There are still areas in which the organisation of health services directly discriminates against people on the grounds of age, resulting in health inequalities.

5.2 Mental health services continue to be planned and provided separately for "adults of working age" and for "older people".⁴⁵⁷ The consequence is that some services are not accessible to older people and that people can be required to leave a service on reaching the age of 65. As an example, in spite of evidence from NICE that there is benefit at any age, the programme to improve access to psychological therapies has been focused on "adults of working age".

5.3 Breast and bowel cancer screening programmes are still not extended upwards to the maximum ages at which people can achieve health gains.

5.4 In other respects NHS service priorities discriminate indirectly against older people by not providing services that are important to maintain health and independence. Chiropody services are essential in helping to maintain mobility as almost a third of older people are unable to cut their own toe nails. Yet NHS foot care services have been scaled back, forcing many older people to pay privately or go without a service.

5.5 Age Concern recommends that the NHS takes effective action to promote age equality in service provision.

6. HEALTH LITERACY

6.1 The trend for increased choice and a greater emphasis on self-management of long-term conditions puts at a disadvantage people who are less "health literate", unless they are offered additional support. The emphasis on electronic information disadvantages people—including many older people—who have not got access to the internet or the skills to use it. There is a risk that those in greatest need will have least access to support.

6.2 Age Concern recommends that additional methods of health communication are made available to those who cannot use mainstream sources of information.

January 2008

⁴⁵⁵ European Nutrition for Health Alliance, *Malnutrition among older people in the community*, 2006.

⁴⁵⁶ HM Government, *Safe.Sensible.Social.The next steps in the National Alcohol Strategy*, 2007.

⁴⁵⁷ Department of Health, *National Service Framework for Mental Health: modern standards and service models*, 1999.

Memorandum by Lloydspharmacy (HI 60)

HEALTH INEQUALITIES

EXECUTIVE SUMMARY

1. Lloydspharmacy welcomes the opportunity to submit evidence to the Health Select Committee's inquiry into the contribution of the NHS to reducing health inequalities.
2. We believe that, by providing easily accessible healthcare, the community pharmacy network holds an unrivalled position and a real opportunity to impact on public health and the reduction of health inequalities.
3. The entire community pharmacy network has the potential to support the NHS in this way and is a solution that can be accessed today to ensure healthcare is delivered to under-served areas and Specialist PCTs.
4. Lloydspharmacy believes that without reforming access to health services, the Government will fail to meet the public health challenge.
5. Incentivising primary care providers to work more closely with one another is paramount to encouraging a vibrant primary care market that addresses the health needs of the local community.
6. We believe that through alignment of the Quality and Outcomes Framework (QOF), GPs should be incentivised to work more closely with pharmacy and vice versa.
7. Lloydspharmacy is not only able to deliver services targeted at health prevention and promotion but is also able to ensure they are easily accessible within the heart of communities they are most required.
8. There needs to be an acceptance of the community pharmacy role, demonstrated by greater integration of NHS primary care workforce and formalised through a new primary care contract for service provision.
9. Providing public health from a non-traditional pharmacy setting is achievable through innovative partnerships with Local Authorities and County Councils. The new Local Area Agreements could be the mechanism for delivering services by joined up working of multiple agencies (public, private and voluntary).

INTRODUCTION

Lloydspharmacy is the largest community based healthcare company in the UK. Our pharmacists manage 1,659 pharmacies where 15,000 health trained staff deliver innovative and quality pharmacy services to our 2 million weekly customers.

Located where people live, Lloydspharmacy enables easy access to healthcare. Our network of pharmacies extends to both remote rural locations and some of the most deprived areas of the UK. Lloydspharmacy believes in allowing patients and the public to take control of their own healthcare by the provision of a range of pharmacy services, including the dispensing and advice of medicines, screening services, and ongoing public health information.

Credentials

- Over 1 million free blood pressure tests
- Over 1 million free diabetes tests
- Over 163,000 people referred to GPs
- Over 1,650 pharmacies providing public health information on obesity, smoking cessation and sexual health
- 20% of pharmacies providing smoking cessation services
- 47% of our pharmacies provide assistance with substance misuse
- 13% of pharmacies provide needle exchange services
- 24% of pharmacies provide EHC services
- Over 1,400 pharmacies have private consultation areas
- Over 390,000 Medicines Use Reviews completed
- Over 300 pharmacies integrated into health centres with GPs and others

COMMUNITY PHARMACY—HELPING TO TACKLE HEALTH INEQUALITIES

Lloydspharmacy believe that community pharmacy should be an integral part of the NHS, with effective pharmacy provision today not only taking the strain off GPs, but also meeting the demands of a society that is constantly mobile and seeks access to healthcare at any time and in any place.

With rising expectations being placed on the NHS, the role of the pharmacist has increasingly been tied in with prevention and diagnosis through the implementation of the Pharmacy contract in April 2005.

Pharmacy not only has the potential to make a far greater contribution to the NHS, but there is a strong economic, as well as practical case for directing more services into pharmacy.

- The pharmacy network is a phenomenally under utilised resource which is expert at delivering local health needs. It should be used to its maximum to help deliver key government objectives, such as the move towards more a more preventative model of care which focuses on “lifestyle diseases” and the management of long term conditions and as announced recently by the Prime Minister⁴⁵⁸.
- Pharmacy premises that are located in under-doctored areas should be extended and adapted in order to increase access to walk-in facilities and the provision of clinical services.
- Better integration and recognition of pharmacists within the broader NHS network would enable more collaborative models of working to tackle the public health challenge and health inequalities.
- Local contracts focused on preventative health measures such as testing should be established that are in line with PCT health priorities.
- Access to healthcare could be increased through providing pharmacy-led services in non-traditional settings.

Improving the nation’s health and specifically tackling health inequalities have been defined as key priorities by the Government⁴⁵⁹. While these challenges are well known, and although some progress has been made to tackle them, effectively addressing disparities in health and public health concerns has proven to be difficult.⁴⁶⁰

UNRIVALLED ACCESS TO HEALTHCARE FOR COMMUNITIES

Located where people live, community pharmacy is well-placed to play a greater role in the delivery of health services. Pharmacist’s exposure to the general public is unique and should be maximised to help deliver key government objectives in the areas of public health and health inequalities. As a profession, we are ready and willing to help deliver the necessary services in the areas of greatest need and while there is recognition amongst government and other healthcare professionals that community pharmacy is capable of delivering such services, there needs to be an acceptance of our role demonstrated by greater integration of NHS primary care workforce and formalised through a new primary care contract for service provision.

LEVERAGING THE PHARMACY NETWORK TO TACKLE HEALTH INEQUALITIES

Health inequalities pose a large threat to the health of our nation. It is widely agreed that areas of social deprivation have a higher prevalence of cancer, coronary heart disease and obesity and the Government has acknowledged that it is many of these areas that are in fact under-served by healthcare professionals⁴⁶¹.

In its assessments of how best to stem the gaps in health provision, Government and PCTs need to consider how they best utilise the existing pharmacy network.

Lloydspharmacy’s network alone has over 600 pharmacies located within under-doctored areas⁴⁶². Our continued presence in such areas provides much needed access to services which help to deliver a range of targeted care to communities. One example of this is in Birmingham, where Lloydspharmacy has 34 pharmacies in Birmingham East and North PCT, which has been recognised as both a Spearhead PCT and under-doctored. Working with the PCT’s recognised key public health priorities; smoking, coronary heart disease and health awareness, Lloydspharmacy has focussed on the delivery of core services to tackle these challenges.

⁴⁵⁸ Prime Minister’s speech to Health Professionals at Kings College, London on Health Reforms, 7 January 2008.

⁴⁵⁹ Secretary of State for Health keynote address to the New Health Network on Health inequalities, 12 September 2007.

⁴⁶⁰ *Our Health Future Secured: A Review of NHS Funding and Performance*, Sir Derek Wanless, commissioned by King’s Fund, 11 September 2007.

⁴⁶¹ New Practices for Under Doctored Areas, Department of Health Press Release, 23 November 2007.

⁴⁶² As defined by the Department as an area or PCT with fewer WTE GPs/100k weighted population than the national average.

Case Study

Working with the Birmingham PCTs, the Heart MOT is targeted towards the male over 40's population and aims to identify individuals with an increased cardiovascular risk.

Early results show that:

- 30.4% of all people accessing the service were identified as having a CVD risk of $\geq 20\%$
- 43.6% of all males accessing the service were identified as having a CVD risk of $\geq 20\%$
- Over 600 patients screened
- 49% referred to GP
- 32% referred due to high CVD risk
- 2% of patients previously not registered with NHS/GP

Lloydspharmacy is not only able to deliver such services targeted at health prevention and promotion but is also able to ensure they are easily accessible within the heart of communities they are most required.

The entire community pharmacy network has the potential to support the NHS in this way and is a solution that can be accessed today to ensure healthcare is delivered to under-doctored areas and Spearhead PCTs. In particular, thought should be given to extending and adapting pharmacy premises that are located in under-doctored areas in order to increase facilities for the provision of clinical services.

Building on the role that community pharmacy already plays in providing testing services, Lloydspharmacy believes that this should be further extended to create better access to services. Many people have very little contact with healthcare professionals; it is generally the "worried well" that proactively seek advice, while those that require care often avoid any form of consultation. Making services such as blood pressure monitoring or cholesterol testing available to public where they naturally gather would help increase people's exposure to healthcare services and advice.

Working in partnership with Kent County Council, we are exploring how best to develop a number of public health pilots in addition to the current services available across Kent. The intention is to demonstrate that by increasing people's access to services and by delivering them outside of traditional locations, cost effective ways of providing health and social care services which ensure maximum public engagement can be achieved. This provision therefore not only helps to improve the health of local communities across Kent but also informs the development of integrated funding models within new Local Area Agreements⁴⁶³.

The following sets out the initial opportunities that have been discussed between Kent County Council and Lloydspharmacy and describes a number of options.

The initial opportunities are centred on:

1. The need to engage school communities to raise awareness of the health issues related to smoking, the introduction of smoke free school grounds, and the need to provide younger people with the opportunity to engage in smoking cessation services.
2. The utilisation of the Kent Gateway strategy. These are "one stop" centres in which the public can access County Council services. The first location is in Ashford and there are plans to open more centres across Kent. Lloydspharmacy in partnership with Kent Gateway will provide targeted public health services in these non traditional settings.

Implementing services such as these, that not only focus on providing public health messaging, but also work to create personalised care has enabled Lloydspharmacy to promote public health and raise health awareness amongst individuals through pharmacy, while also supporting the NHS and other local services.

In Norfolk, we are also working locally to deliver an activity programme, "Fit Together". The initiative, which was developed in partnership with Sport England, promotes small increases in activity levels to improve overall health and well-being. "Fit Together" particularly focuses on walking and cycling and is promoted in pharmacy in conjunction with existing pharmacy services including diabetes testing, blood pressure checks and Medicines Use Reviews (MURs).

Better integration and recognition of pharmacists within the broader NHS family would enable collaborative models of working which help deliver public health services, to not only the broader population, but also to areas of greatest need.

Whilst work in Kent and Norfolk is still in its very early stages, the projects help demonstrate how pharmacy expertise can be innovatively utilised to increase access to services.

⁴⁶³ The LAA is designed to allow services to be delivered in a more joined-up way by bringing together partners from the public, private and voluntary sectors and pooling funding streams of each partner into a single pot, designed to avoid duplicating effort and wasting money.

EFFECTIVE DELIVERY OF SERVICES

Lloydspharmacy believe that service provision will form an increasing part of pharmacy's future role. We have invested in consultation areas, which are now equipped with PCs, promoted MURs and enhanced services, as well as the provision of services such as diabetes monitoring, blood pressure testing and healthy heart checks.

However, there are differing levels of engagement within the overall pharmacy network. While many pharmacies are proactively driving services and are keen to develop this further, others remain focused solely on dispensing.

The over-riding majority of current remuneration is focused towards dispensing and fixed fees—for many, the most profitable action is to focus on dispensing alone. The ongoing volume increase of prescriptions (which has outstripped funding growth), and the ongoing rising cost base and inflation, has meant many pharmacies are predominantly focused on dispensing at the minimum cost achievable.

Although efficiency is desirable, shifting new or existing funding towards quality based payments and developing service capability will ensure that these areas are also given proper focus (by the whole network).

In our submission to the Galbraith review; "*Review of contractual arrangements for NHS pharmaceutical services in England*", we proposed reallocating some of the variable dispensing fee (the Practice Payment). Over time, a proportion of pharmacy income for pure dispensing activity could be reallocated to allow an increased proportion to be used to drive behaviour towards the service plus dispensing agenda.

It also suggested a two tier variable dispensing payment—a lower rate for pharmacies providing only essential services, and a higher rate for pharmacies capable of providing a given range of advanced (or enhanced) services.

Our proposed Framework is a value for money mechanism designed to provide patients and the public with high quality services, enhance PCT autonomy, link primary care providers, deliver NHS public health goals and provide business certainty for pharmacy contractors.

The Framework combines three elements, underpinned by a new financial model for community pharmacy:

1. An objective, transparent methodology to determine where and whether a pharmaceutical contractor can provide NHS pharmaceutical services—"Pharmaceutical Needs Planning" (PNP) assessment.
2. A standard contractual framework to enable PCTs to more effectively commission pharmacy, GP, dentist and ophthalmology services.
3. Incentives to create new models of dispensing which would enable greater pharmacist interaction with patients and the public.

EQUITABLE ACCESS TO HEALTH SERVICES

Lloydspharmacy believes that in the pharmaceutical market, regulation is a prerequisite for the protection of public health and the public interest. The rules that control the balance between cost containment and competition must not put at risk access to public health service provision. Without these controls, we believe that there would be an under provision of health services to the public, as the concentration and clustering of pharmacies around GP surgeries and health centres would increase as each contractor competes for prescription business. We do not believe that further deregulation of the pharmacy services market would bring additional value to the general public or the Treasury.

We believe that Government has a duty of care to ensure equitable access to healthcare for the population and that there is a strong continuing need for some regulation in order to achieve geographical spread of pharmacy provision.

The current arrangements enables pharmacies to remain in communities, neighbourhoods and rural locations as well as improve access and choice in metropolitan areas— addressing inequalities in healthcare provision, particularly in under doctored areas as already highlighted.

INCENTIVISING GREATER COLLABORATION

Incentivising primary care providers to work more closely with one another is paramount to encouraging a vibrant primary care market that addresses the health needs of the local community. In particular, Lloydspharmacy believes that through alignment of the Quality and Outcomes Framework (QOF), GPs should be incentivised to work more closely with pharmacy and vice versa.

Whilst we propose that the QOFs of various health care professionals should be aligned, the pace of this alignment must be thought through carefully so as not to overburden primary care health professionals and their patients with unreasonable activities and targets. Future enhancement of our proposed community pharmacy QOF should be an iterative process where the “bar” is raised so that over time, as the range of indicators is raised there will be convergence of the GP and community pharmacy QOF to ensure that continued improvements in service, quality and patient outcomes are maintained through the collaborative activities of community pharmacy and GPs.

Although the opportunities to expand the existing contractual framework for community pharmacy and the potential value of adding a QOF element are clear, there are a number of requirements to enable pharmacy to effectively participate.

Pharmacists must be enabled to access the NHS Care Records System in order to ensure cohesive service provision across professions. In addition to this, it will also be important to agree a standardised reporting system to ensure consistent patient tracking and follow-up.

ENSURING THE APPROPRIATE DIRECTION OF SERVICES

Community pharmacy has a tremendous role in assisting with the management of Long-Term-Conditions. As the second phase of Lord Darzi’s NHS Reviews explores various clinical pathways, it is important for the Government to recognise where community pharmacy can contribute to the patient journey, from prevention, detection and the long-term management of illness.

USING PHARMACY TO FACILITATE CHOICE

Improving awareness of choice in primary care services can also improve access to healthcare as well as ensure the appropriate use of services. Utilising the level of exposure community pharmacy already has with the public and the expertise the profession has in delivering customer choice, Lloydspharmacy believes that community pharmacy should be leveraged to highlight patient choice. Through sign-posting local health services and raising awareness of the appropriate use of services, community pharmacy could do much to alleviate the strain on GP practices and refer patients and the public to the most appropriate health service provider.

CONCLUSION

The answer to the question “Can the NHS make an impact on reducing health inequalities” is yes, and how this is achieved in a timely manner because of the urgency in need requires leadership from all stakeholders.

Success in reducing health inequalities and improving public health would be demonstrated by the NHS, Local Authorities, Voluntary sector and the Private sector agreeing how to work differently together.

Community pharmacy can make a significant contribution by:

1. utilising their access to people living in under-doctored areas by developing facilities to provide “walk-in” pharmacy led services
2. delivering services targeted at prevention, such as reduce smoking, lowering blood pressure, cholesterol and weight would make positive impact in reducing health inequalities
3. realising the cost effectiveness of public health services being offered in pharmacy and the long term benefits to local people and the health economy

The levers that would enable change to take place are:

- Community pharmacy being recognised by all stakeholders as integral to the solution to reduce the impact of health inequalities as part of an
- integrated local plan.
- Incentivising primary care providers to work jointly and alignment of professional contracts.

Memorandum by the Chronic Pain Policy Coalition (HI 61)

HEALTH INEQUALITIES

1. INTRODUCTION

1.1 The Chronic Pain Policy Coalition (CPPC) unites professionals, parliamentarians and patients who have joined together to make a positive contribution to improving the lives of people with pain and their families by working in collaboration with each other. The CPPC works to develop and coordinate a strategy for improving the prevention, treatment and management of chronic pain in the UK.

1.2 The Executive Committee is formed of senior representatives from a range of stakeholders including;

Baroness Rennie Fritchie—CPPC President

Dr Beverly Collett—Consultant in Pain Management, University Hospitals of Leicester

Sylvia Denton—Past President, Royal College of Nursing

Jean Gaffin—Trustee, St Luke's Hospice Harrow

Dr Joan Hester—President, British Pain Society

Dr Martin Johnson—Chair, Pain Committee, Royal College of General Practitioners

Clive Jones—Director of UK Corporate Affairs, Napp Pharmaceuticals Ltd

Beatrix Maynard—Management Consultant

Professor David Rowbotham—Faculty of Pain Medicine, Royal College of Anaesthetists

Dr Gabriel Scally—Regional Director of Public Health, Government Office South West

Nia Taylor—Chair, Patient Liaison Committee British Pain Society and Chief Executive, BackCare

1.3 The CPPC is supported by The Royal College of Anaesthetists, The Royal College of General Practitioners, The Royal College of Nursing, Royal College of Obstetricians and Gynaecologists, The Royal College of Physicians, The Faculty of Occupational Medicine, The British Pain Society, British Society for Rheumatology, The British Medical Acupuncture Society, Action for ME, Action on Pain, BackCare, Derbyshire Chronic Pain Support Group, emPower, Endometriosis SHE Trust, National Lichen Sclerosus Support Group, Pain Association Scotland, Pain Concern, Pain Relief Foundation, Pelvic Pain Support Network, Poole Endometriosis Support Group, RSD UK, Scleroderma Society, Shingles Support Society, Spinal Injuries Association, The British Polio Fellowship, The Migraine Trust, Vulval Pain Society, Grunenthal, Janssen-Cilag Ltd, NAPP Pharmaceuticals, Novartis, Pfizer and Sanofi Pasteur MSD.

2. EXECUTIVE SUMMARY

2.1 7.8 million people live with chronic pain in the UK. One-third of households have at least one adult who is in pain. This means 1 in 7 people in every single parliamentary constituency.

2.2 Chronic pain can affect people at any age and at different stages of their life. In the UK, 75% are of working age between 18 and 65 years of age.

2.3 The negative effect of chronic pain on quality of life can be considerable—with 24% of people being diagnosed with depression.

2.4 There are severe economic consequences for the individual and their family as 25% of people with pain lose their job.

2.5 There are significant economic consequences for the wider economy, for example the total cost of back pain being £12.3 billion in 2000.

2.6 Pain Management Services are patchy and variable around the country. Current inequalities in access to adequate pain management services in the UK are unacceptable if the NHS is to be genuinely patient-centred.

2.7 Management of chronic pain requires a biopsychosocial approach. General Practitioners cannot currently always manage chronic pain alone. There is a clear necessity for a different way of managing pain within the health community.

2.8 Improved pain management could be achieved by implementation of the Chronic Pain Policy Coalition's Five Point Manifesto.

2.9 Improved pain management could be achieved by service reconfiguration without significant extra resources. There is a clear imperative to work "smarter".

2.10 There is necessity for a joined-up strategy between occupational health services, primary and secondary care in the management of patients with chronic pain.

2.11

<i>Education</i> So that pain is an integral part of all professional training	<i>Parliamentarians Should</i> Ensure that Government gives more priority to pain education as an important part of effective chronic pain management.
<i>Empowerment</i> To support people to make decisions about their condition	Liaise with the local health sector to improve services for people living with chronic pain.
<i>Collaboration</i> So that all stakeholders share in a joined up strategy	Support and encourage the development of local multidisciplinary pain management services and commit to reforming the “Med 3” sick note.
<i>Early Access</i> To prevent acute pain becoming chronic pain	Ensure that the Government supports Primary Care Trusts and employers in taking a long term view on tackling chronic pain.
<i>Measurement</i> Of pain as the 5th Vital Sign	Campaign for the adoption of Pain as the 5th Vital Sign by all health care professionals.

3. BACKGROUND

3.1 7.8 million people live the chronic pain in the UK. This is equivalent to about one in seven people in every single parliamentary constituency.

3.2 Pain in a major humanitarian issue. The negative effect of chronic pain on the daily lives of individuals and their families is enormous. Twenty-five per cent of patients with chronic pain lose their jobs and 24% are diagnosed with depression (Breivik HB, Collett BJ et al. Survey of chronic pain in Europe: Prevalence, impact on daily life, and treatment. European Journal of Pain 2006;10:287–333)

3.3 The consequences for the UK economy are of huge significance. Total cost of back pain alone was £12.3 billion in 2000 (Maniadakis N, Gray A. The economic burden of back pain in the UK. Pain 2000; 84: 95–103). Department of Work and Pensions data estimates the annual cost of incapacity benefit for claimants with musculoskeletal disorders to be £126 million in 2004–5 (Department of Work and Pensions 2007) and chronic pain is a major component of these disorders. It is estimated that 119 million working days are lost each year to back pain (www.backcare.org.uk,2007).

3.4 Chronic pain is one of the commonest reasons for a patient to visit a GP, accounting for 4.6 million GP appointments each year at a cost of £69 million (Besley J. Primary care workload in the management of chronic pain: A retrospective cohort study using a GP database to identify resource implications for UK primary care. Journal of Medical Economics 2002;5:39–50). This represents a resource cost equivalent to around 800 full-time GPs per year.

3.5 Persistent pain stimulates a vast number of prescriptions, investigations and referrals, causes frustration in its resistance to treatment and leaves patients and doctors with low expectations of successful outcome.

3.6 Better management of acute pain may prevent chronic pain becoming entrenched. In addition, Pain Management Services in secondary care have traditionally been seen as a “Cinderella service” with long waiting lists and only to be tried when everything else has failed. A consequence of this is that there are often delays until a patient sees a health care professional interested in relieving them of their pain and returning them to functionality. Once off work with back pain for more than six months, there is less than a 50% chance of them ever returning to work.

3.7 When pain is associated with a disease or condition (eg cancer, inflammatory conditions), the specialists dealing with the patient may be less interested in the pain than in the progression and management of the disease, and therefore spend little time in dealing with the pain. Yet for patients we know that adequate control of pain and discomfort is very important and affects their ability to deal with other aspects of their condition.

3.8 In March 2000, the Department of Health published the Clinical Standards Advisory Group (CSAG) “Services for patients with pain”. This report made certain recommendations, but was never implemented as the NHS was re-structuring service provision generally at that time. However, reference is still made to this document within the House when Parliamentary Questions are answered. These answers reflect a lack of understanding within the Department of recommendations made without any attempt to see they are implemented, (eg no targets for improving pain management and no NSF), and ignoring the fact that the CSAG Report was never sent to the newly emerged NHS bodies.

3.6 In June 2007, the Chronic Pain Policy Coalition launched a Five Point Pain Manifesto to present some forward-looking and cost effective solutions to the problem of chronic pain. A copy of this manifesto is available.

Our manifesto emphasised:

1. Early access: to prevent acute pain becoming chronic
2. Pain should be viewed as the 5th Vital Sign—ie health professionals should routinely ask patients if they are in pain and this pain should be measured so that the pain can be treated and subsequently re-assessed.
3. Empowerment: to support people making decisions about their treatment in the way that patient information prescriptions currently being piloted
4. Collaboration: so that all stakeholders share in a joined-up patient strategy
5. Education: so that pain is an integral part of all professional training.

4. SUGGESTIONS FOR TACKLING INEQUALITIES

4.1 Patients need better access to Pain Management Services in primary care, and in secondary care for those who need it. The Chronic Pain Policy Coalition strongly supports the development of an 18 Week Commissioning Pathway for Chronic Pain. However, we need to ensure that patients struggling to manage their pain are identified early in primary care and appropriate management instituted.

4.2 In addition, any improvement to pain management whether in primary or secondary care or both must encompass

- demand management—making sure the right person gets seen in the right place at the right time
- service design—structuring the service to permit a biopsychosocial approach
- appropriate management of patient expectations
- clear care pathways to take a person in and out of the service.

4.3 We present below some examples of excellent innovative services currently being undertaken in primary and secondary care that emphasise how a different approach to acute and chronic pain management may improve patient care. However, we should like to emphasise that these examples are not the current common method of chronic pain management across the UK and disseminating these examples of good practice and encouraging their adoption would benefit millions of patients.

4.4 We should like all patients to have the opportunity of such services.

5. CASE STUDIES

These are only resumes of the services and full details can be provided on request.

5.1 *Tower Hamlets Primary Care Trust.*

This project, which will be launched on 15th January 2008, offers a unique opportunity to improve the care of Tower Hamlets residents suffering from chronic musculo-skeletal pain. Using a bio-psychosocial model, patients will be helped to self-care and avoid long-term sickness and disability. This will be achieved by establishing a prompt patient triage and assessment service which, using an interdisciplinary team will provide a clear strategy of care leading ultimately to self-efficacy. The team will work closely with the physiotherapy department at Mile End hospital but there will also be links with external agencies such as providers of self care management.

The project will be underpinned by an education programme provided by the team for other health care professionals. There will also be robust evaluation of the service including a formal assessment of lay-led patient programmes. This project follows the model that has been successfully pioneered in Southampton although it will be the first to effect these changes in an inner city multicultural environment.

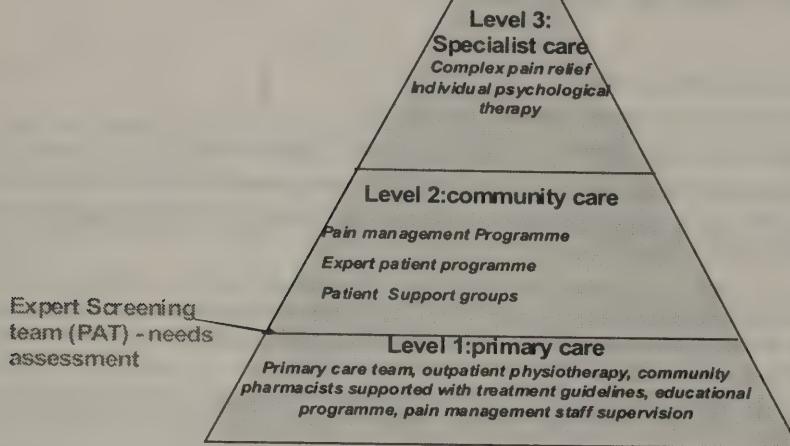
The new service will provide a new, improved pathway for patients with the key aims of the service being:

- Early access to assessment by a specialist interdisciplinary team to help prevent people having long term health problems.
- Use of an integrated specialist service of secondary care outreach consultants, PCT Allied Health Professionals, Clinical Psychologists and a Health and Advice worker. These will be supported by dedicated administrative staff.
- Ongoing education and mentoring for other Health Care Professionals in the management of this complex group of patients.
- Development of structured education programmes to enable patients effectively self manage. All people attending the service will be offered the opportunity to attend an appropriate self management course.
- Providing appropriate information and advice about other important areas such as housing, ESOL and work related issues
- Providing a full advocacy service for non-English speakers.

5.2 *The Southampton Pain Services Project “Managing Pain Management”.*

A local services framework was agreed using a biopsychosocial approach at all levels of care as illustrated below:

Management Of chronic pain population [Approximately 50,000 in Southampton]



The emphasis is on viewing chronic non malignant pain as a long term health problem. The emphasis has been to ensure that primary care practitioners have the appropriate skills and resources to manage the vast majority of patients. Only a few (approximately 450 patients a year) are taken into specialist care for treatment but that treatment has clear end points. The principal changes to the service have been establishing treatment and referral guidelines for general practitioners, backed up by consultant visits to each practice, establishing a triage team, increasing the number and range of self management programmes in the community and setting up patient led support groups. The secondary care service was redesigned to increase emphasis on addressing complex psychosocial needs. All patients are required to opt in to differing arms of the service once choices have been thoroughly explained either through written information or during triage/assessment.

Outcomes

An efficient, effective, sustainable service has now been established, involving a Care Pathway stretching across Primary and Secondary Care. Improved patient access has been achieved in largely through effective triage of referrals. GP's refer using an agreed and detailed proforma which is shared between all primary care based musculoskeletal services. Audit of outcomes at present shows that 30% of patient referrals can be either discharged after giving further advice or redirected based upon information given in the referral letter alone. 11% of patients do not opt into the service. DNA rates are very low. 36% of patients receive secondary care treatment. 5% opt to go directly to a self Management Programme with many of those seen in secondary care being referred at a later stage. The number of patients appropriate at assessment for a self management programme has increased from 30% to 60%.

Redirection to the Expert Patient Programme and community rehabilitation teams are important and appropriate pathways.

A patient satisfaction survey showed 75% were highly satisfied with the outcome of assessment. For many it was the first time they felt understood.

There was a small initial cost to fund the Triage team and an increase in self management programmes for the more complex patients. There have been cost savings elsewhere with injection therapy, medical follow-ups and acupuncture being substantially reduced.

5.3 Painmanagementsolutions

Pain Management Solutions Ltd was formed with the vision to revolutionise the way in which pain management is delivered within the NHS. Pain Management Solutions believe that by introducing community based services, whilst at the same time developing and training primary care teams in the art and science of pain management, the financial cost and socio-economic burden (chronicity) of long-term benign pain can be critically reduced.

Pain Management solution's services include:

- Community Based Pain Management for Sheffield PCT
- Choice & Book for Derbyshire County PCT
- Extended Choice Network for Barnsley PCT (Delivered in the local community)

Pain Management Solutions is establishing itself as a vehicle to bring the expertise of pain management into the community. In doing so patients are accessing services more rapidly, GPs and their clinical teams are being trained and developed, and the overall cost of this therapy area to the NHS is being reduced. Furthermore, commissioners and other users have access to information on clinical quality and contractual performance as well as cost effectiveness.

They intend to develop their service further; and already have interest from commissioners & clinicians in several different areas of the North of England.

6. RECOMMENDATIONS FOR ACTION

6.1 The Chronic Pain Policy would humbly suggest that:

- improved pain management is a significant public health issue
- current inequalities in access to adequate pain management services in the UK are unacceptable.
- improved pain management could be achieved by improved dialogue and joint working between primary and secondary care.
- improved pain management services could be achieved with recognition of chronic pain as a condition is its own right and with a focus to manage this problem, with early intervention, with better primary care education and with resources re focused to deal with pain and functional impairment associated with pain
- improved pain management could be achieved by implementation of the CPPC Five Point Manifesto

6.2 The CPPC supports the implementation of the Musculoskeletal Services Framework, but has concerns that this will be patchy and variable around the country. In addition, it deals only with musculoskeletal pain problems.

6.3 The CPPC welcomes the opportunity to present models of pain management services in primary care and models that incorporate productive cross boundary working across primary and secondary care as good practice which will improve the management of this condition, improve quality of life for many patients and improve functionality and the ability to participate fully in a working and social life.

January 2008

Memorandum by the Assura Group (HI 62)

THE CONTRIBUTION OF THE NHS TO REDUCING HEALTH INEQUALITIES

THE ASSURA GROUP

Assura invests in primary health care property, by developing and retaining primary care resource centres, GP surgeries, polyclinics and community hospitals for long-term investment, and is also involved in a number of LIFT schemes. We are currently involved in approximately 150 sites around the country and aim to be one of the UK's largest independent healthcare provider organisations by 2010. We are an expanding care provider, seeking to establish for the long term, in those places that most require servicing.

As a mature and established primary care support service organisation, the Assura Group and its subsidiaries, Assura Property, Assura Medical and Assura Pharmacy, work together to deliver solutions to local primary care needs. We have so far committed more than £500 million to the sector and are on target to invest or commit £750 million of capital on health care by 2009. This significant expansion of premises is entirely in line with the Government's aim of bringing in private capital to improve services, particularly in deprived communities.

EXECUTIVE SUMMARY

Assura welcomes the Health Select Committee's Inquiry which will examine the extent to which the NHS can help to achieve a reduction in health inequalities, particularly through primary care and public health services. Assura is encouraged by the government's overall ambition to eradicate the post code lottery which exists around the country and to ensure health equality is realized by sustained investment in deprived communities.

Assura strongly supports the aims of the Government's White Paper "*Our Health, Our Care, Our Say*" which acknowledges that the private and independent sector can play a vital role in supporting the modernisation of primary care services. In line with the White Paper, Assura also believes that the expertise and investment brought by the private sector can and does play a vital role in tackling health inequalities.

Throughout the country hundreds of GPs are working with Assura to form provider organisations and deliver community based care closer to their patients. In many deprived communities Assura is offering integrated facilities and support systems which enable GPs to undertake a much wider range of services. Driven by levers including Practice Based Commissioning this is putting power in the hands of clinicians and practitioners who understand the needs of their local community and can drive up standards of care for all. Making these policy drivers work effectively across the country will be central to maximizing the opportunities afforded in primary care.

HEALTH INEQUALITIES

1. Our dealings with many of the PCTs around the country have enabled us to build up significant knowledge and expertise in primary care services. The Assura Group therefore believes that access to GP services as well as quality of GP services is key in order to reduce health inequalities. Primary care is of particular importance in deprived areas to reduce these inequalities and Assura was therefore particularly supportive of the publication of *“Our Health, Our Care, Our Say”* and the renewed emphasis it places on primary health care.

2. Continuing reform and modernisation is critically important to ensure that patients gain maximum benefit from the significant funding increases within the NHS and that remaining health inequalities are tackled appropriately. The independent sector can play a vital role in supporting the modernisation of primary care services and we welcome the government’s sustained acknowledgement of this. It is vitally important that the government seeks consensus wherever possible on its health service reforms and ensures that the market in primary care continues to grow and mature. The introduction of private providers is a tremendous boon for the NHS in financial terms but also in terms of expertise, competitiveness and service provision.

3. Assura has often filled gaps in primary care services in deprived areas through our unique financial and delivery model. If government objectives for primary care in poorer areas are to be realised, the private sector’s skills, expertise and funding for facility development is essential. As there remain significant geographical disparities in terms of health outcomes, Assura recognises that the facilities being delivered need to be reflective of the needs of the local community and are provided promptly and with the opportunity for refurbishment and update.

4. Cross-subsidy from Assura’s three divisions; Assura Property, Assura Medical, and Assura Pharmacy, allows the development of major primary care developments and GP led Polyclinic-type models. It also gives far better value to the taxpayer through improved efficiency savings. 50:50 joint ventures with GPs are formed to enable them to provide out-patient and diagnostic procedures in the community. These advanced facilities help to enable the reconfiguration of secondary care services into primary care in line with patient needs and the wider NHS agenda. This collaborative approach between the GP community and Assura leads to improved utilization of healthcare professionals across a patch and helps support a greater skills mix amongst clinicians within a Practice.

5. The Assura model carries the whole risk in developing modern, high quality facilities for primary care by enabling us through our large equity base to speculatively acquire and develop new primary care facilities in areas ahead of a final decision by PCTs on funding. This allows Assura to go into deprived areas that traditionally have not received as much investment whether that is through high land costs or low GP numbers and to develop facilities which support that local community.

6. There is a reduced appetite amongst GPs for owning property with the introduction of new contracts for GPs and the focus on larger primary care centres. This reduces the burden of property ownership, allows GPs to focus on service delivery and can unlock capital value in premises in a tax efficient manner. It also means that GPs who were previously tied up in asset management are freed from that responsibility helping ensure a focus on service redesign and improved care pathways for all patients.

7. We have found that our modern facilities encourage GPs to relocate into areas they have considered too unfavourable and deprived in the past. It is also clear that modern, technologically advanced primary care facilities—one-stop primary care centres, polyclinics, community hospitals and super surgeries—offering co-location of services are key to providing a patient-led, high quality health service.

8. Significant sums of money have been put into deprived communities over the last 10 years but persistent health inequalities remain. This is in many cases due to the fact that whilst the solutions and the services may be in place, they are too often not being accessed. In these areas PCTs must work closely with their Local Authority partners to look at education and health promotion as well as simply waiting for patients to “come to the GP”. Progressive primary care centres will play an integral part in delivering this vision and will need to look outwards as well as looking inwards at the services they provide.

9. Primary care has rightly been put at the centre of the government’s reform agenda with policies such as Practice Based Commissioning, Payment by Results (in respect of tariff unbundling) and Any Willing Provider contributing to this direction of travel.

10. Practice Based Commissioning encourages provision of appropriate and convenient services for the patient. In order to address health inequalities it is, therefore, vital to roll out Practice Based Commissioning in a speedy and efficient manner and to ensure effective take up by GPs who are not merely the most entrepreneurial or progressive. Giving GPs more power over resources used by their patients to deliver better care is important to meet specific local needs and thereby reduce health inequalities as is the shift towards “fair-share” budget setting.

11. Practice Based Commissioning also allows GP practices to keep a proportion of any “efficiency gains” resulting from more cost-effective ways of treating patients, which can then be ploughed back into developing new services. By working with Assura and offering facilities and services which take the burden off the acute estate these savings can be manifest and when put back into the local health economy represent excellent value for money.

12. Without Practice Based Commissioning one of the levers for change would not exist. However, Practice Based Commissioning is merely a lever and is insufficient in itself to improve health outcomes and should not be seen as the end of the process. Using existing service providers appropriately and imaginatively and moving towards “practice based provision” must be the aim of the reform process. This means working alongside as opposed to against clinicians throughout the country, engaging them in their patients’ care and providing them with the tools to drive up standards. GP-led schemes such as the Assura Limited Liability Partnership (LLP) model does just this and can be a real vehicle for change.

13. The government has thus far pursued an appropriate policy of encouraging the independent sector to enter the market and to compete for services where best value can be demonstrated. Any Willing Provider does this by ensuring that no income guarantee is made and no false monopolies are created. Under Any Willing Provider GPs can offer genuine choice to patients in a locality and the local health economy can become far more efficient. Assura would like to see this policy driven forward across the country with the presently patchy implementation smoothed over to enhance patient choice.

14. As with Practice Based Commissioning however, it is vital that those entering the market do so by moving in the same direction as the GP community and not against it. An Assura LLP supports this process and is able to operate where Any Willing Provider criteria is being properly followed. Enforcement of this guidance is crucial in ensuring a rich mix of providers in every area and much greater efficiency.

15. Similarly the role of the tariff has been important in driving forward the care closer to home agenda and Assura sees the tariff as having a critical future role in reducing health inequalities. Where the tariff can be used to incentivise new providers to move into an area that has problems with under-capacity it can be a real lever for change.

16. We urge the government to ensure that it continues on the road to reform and uses companies like Assura to deliver sustained and increased investment, both in premises expansion but also in service redesign, which is a necessary outcome of the significant increase of NHS expenditure since 1997 and the care closer to home agenda.

RECOMMENDATIONS

1. Practice Based Commissioning has had a very mixed take up throughout the country and Assura’s experience of this is that where it has been embraced significant service performance improvements result. Focusing on the 38 most deprived PCTs, the government should offer support to Trusts and GPs in taking advantage of the opportunities afforded by Practice Based Commissioning and to ensure patients in deprived communities benefit from greater choice and improved services close to their homes.

2. Any Willing Provider is not being embraced universally and where it is not choice and improved service design is not being realized. A failure to tackle this problem, which has been generated partly by a lack of understanding and also a lack of prioritization, has meant that providers wanting to enter a market “at risk” are reluctant to do so. The government must pursue this policy fully and ensure that PCTs make Any Willing Provider a core part of their strategic planning.

3. The role of the tariff must be looked at and expanded to bring in appropriate providers into deprived communities. As it becomes unbundled the tariff has the potential to act as a lever for reform; being lowered in parts of the country with surplus capacity and increased in areas where there is a dearth of capacity. The government must look urgently at how the tariff should be used over the next five years to improve health outcomes for deprived communities.

4. The government must also ensure that throughout this reform process levers for change are being used that work with not against clinicians. Assura has found through many years working in localities throughout the country that this is by far the most effective way to get the most out of the system. Given that inefficiencies tend to be worst in the more deprived communities getting this right and prioritizing this partnership approach will be integral to successfully reducing health inequalities.

CONCLUSION

Overall we support the Government's aims to reduce health inequalities by expanding, improving and increasing primary care as a majority of patients have their initial contact with the NHS through primary care services. However, Assura feel that there is a need to put an even stronger emphasis on the continuation of Practice Based Commissioning, Any Willing Provider and the role of the tariff and to support PCTs with effective implementation; something that is presently not routinely happening. It must also ensure that even within a competitive marketplace structures are in place to ensure all providers link well with the clinicians who are delivering the service.

The direction of travel for making this happen has already been set out, however the big challenge for the next five years will be making it happen on the ground and ensuring that those PCTs with the worst health outcomes embrace reform and deliver change.

January 2008

Memorandum by ASH (HI 63)

HEALTH INEQUALITIES

ABOUT ASH

1. Action on Smoking and Health (ASH) is a London-based health campaigning charity, working to eliminate the harm caused by tobacco. As smoking is the major recognisable cause of social inequalities in health, ASH welcomes the opportunity to contribute to this consultation. Set up by the Royal College of Physicians, ASH is funded by the British Heart Foundation, Cancer Research UK and the Department of Health.

EXECUTIVE SUMMARY

2. Tobacco use is the major preventable cause of death killing around 114,000 smokers each year and responsible for 29% of all cancer deaths⁴⁶⁴, 17% of deaths from heart disease and 80% of deaths from chronic obstructive lung disease (see Appendix 1 for a more detailed breakdown).

3. There is an iron chain linking deprivation and smoking.⁴⁶⁵ Smoking accounts for half the difference in life expectancy between social class 1 and 5. Death rates from tobacco are two to three times higher among disadvantaged social groups than among the better off.⁴⁶⁶

4. Our submission relates only to how tobacco control can contribute to reducing health inequalities, by reducing smoking prevalence.

5. Increasing the price of smoking is the most effective means of helping smokers quit.^{467, 468} However, tobacco tax is strongly regressive and for those smokers who don't quit it can increase health inequalities, particularly for less affluent smokers. On the other hand, genuine price increases do help lead some smokers to quit and make very substantial health and welfare gains for those that do quit. This poses a dilemma, which can be resolved only by making the greatest possible efforts to motivate and assist smokers to quit in response to increases in taxation.

6. Preventing people from starting to smoke or helping them quit requires measures at population level that impact on all the key levers, price, promotion, place and product, also known as the marketing mix.⁴⁶⁹

7. The NHS impacts on smoking behaviour at individual level rather than population level. The NHS is responsible for identifying smokers, providing individual smoking cessation services and routine follow up where necessary.

8. Services provided by the NHS directly can only realistically make a partial contribution to the overall reduction in smoking prevalence, but broader population measures are always going to play a more significant role in reducing smoking prevalence overall. The DH target of 800,000 4-week quitters over three years represented at most 160,000 long-term ex-smokers who would not otherwise have given up smoking during that time frame. This represents a prevalence reduction of around 0.1% a year⁴⁷⁰ or a quarter of the current rate of decline.⁴⁷¹

⁴⁶⁴ British Heart Foundation, 2004.
www.heartstats.org

⁴⁶⁵ ASH press release 9th October, 2006 Major Online Mapping Project Shows "Iron Chain" Between Smoking and Deprivation
http://www.newash.org.uk/ash_b5hdcln5.htm

⁴⁶⁶ Acheson, D. Independent Inquiry into Inequalities in Health. London, TSO, 1998.

⁴⁶⁷ Jha P, Chaloupka FJ. Curbing the Epidemic: Governments and the Economics of Tobacco Control. World Bank, 1999.

⁴⁶⁸ Hu T-W, Sung H-Y, Keeler TE. Reducing cigarette consumption in California: tobacco taxes vs. an antismoking media campaign. *Am J Public Health* 1995b;85(9):1218-22.

⁴⁶⁹ http://en.wikipedia.org/wiki/Marketing_mix

⁴⁷⁰ West, R. Stop Smoking Service Quality and Delivery Indicators and Targets. A Briefing for the Healthcare Commission. July 2004.

⁴⁷¹ Jarvis MJ. Monitoring cigarette smoking prevalence in Britain in a timely fashion. *Addiction* 2003;98:1569-74.

9. Both population and individual measures need to sit within a comprehensive, adequately funded tobacco control strategy.

10. Targets are necessary to incentivise effective action to reduce smoking prevalence, and specifically target the most disadvantaged smokers. Targets need to be more ambitious if health inequalities are to be significantly reduced.

A COMPREHENSIVE TOBACCO CONTROL STRATEGY

11. Tobacco control is central to any strategy to tackle health inequalities and to any prevention strategy. Stopping people smoking is an intervention which can act before disease develops, so it is more effective than any screening programme⁴⁷². For example 61% of aortic aneurysm resulting in death in men is due to smoking (see Appendix 1). It also results in an immediate reduction in costs to the NHS, for example in costs of hospitalisation for heart disease⁴⁷³ and statin use.⁴⁷⁴

12. Since the white paper *Smoking Kills* in 1998⁴⁷⁵, many significant measures have been achieved, such as a ban on tobacco advertising and promotion and comprehensive smokefree legislation. However, the UK still lacks a co-ordinated national strategy, as required by the WHO's Framework Convention on Tobacco Control, which the UK has ratified.⁴⁷⁶

13. Such a strategy should be adequately funded and include comprehensive measures to tackle smoking prevalence as set out below, with a proper process in place for monitoring, evaluation and updating the strategy over time.

14. Illegal drug use is estimated to cost the health service only around £0.5 million each year compared to the annual cost of smoking-related diseases of £1.7 billion.¹⁵ The Government spent £736 million on treatment and prevention on illegal drugs in 2005–6⁴⁷⁷ (not including all the crime and enforcement costs of illegal drugs). Yet it is estimated there are only around a total of 350,000 problem drug users.⁴⁷⁸ In comparison spend on tobacco control by DH was less than £150 million in 2005–6, for 10 million smokers.⁴⁷⁹

THE EXTENT TO WHICH THE NHS CAN CONTRIBUTE TO REDUCING HEALTH INEQUALITIES

The NHS Stop Smoking Services

15. The NHS Stop Smoking Services, first introduced in Health Action Zones, are a very cost effective means of tackling what is chronic relapsing disease, tobacco addiction. A recent analysis shows that the average cost per life gained for every smoker was under £700, one of the most cost effective interventions and well below the benchmark of £20,000 per quality-adjusted life-year saved (QALY) that is used by NICE to determine whether a treatment should be funded by the NHS.⁴⁸⁰

16. Furthermore, the findings of the evaluation of the services were that the services are effective at reaching more disadvantaged smokers.⁴⁸¹ This is supported by the survey figures from the ONS studies which show that in 2005 8% of routine and manual workers said they had been referred or self-referred to a stop smoking service, compared to 4% of professional and managerial workers (and 10% of intermediate workers).

⁴⁷² Carvel, J. Brown plans killer disease screening on NHS for all men as they reach 65. *The Guardian* 5 January 2008.

⁴⁷³ Naidoo B, Stevens W and McPherson K. Modelling the short term consequences of smoking cessation in England on the hospitalisation rates for acute myocardial infarction and stroke. *Tobacco Control*, 2000; 9: 397–400 doi:10.1136/tc.9.4.397.

⁴⁷⁴ Wanless D. *Securing our Future Health: Taking a Long-Term View*. Final Report. London, HM Treasury, 2002.

⁴⁷⁵ Department of Health. *Smoking Kills. A White Paper on tobacco*. London: The Stationery Office, 1998.

⁴⁷⁶ WHO Framework Convention on Tobacco Control. Adopted May 2003, Geneva.

<http://www.who.int/tobacco/framework/en/>

⁴⁷⁷ Home Office website accessed 9 January 2008.

<http://www.drugs.gov.uk/drug-strategy/funding/>

⁴⁷⁸ Drugs—facing facts The report of the RSA Commission on Illegal Drugs, Communities and Public Policy. RSA March 2007.

⁴⁷⁹ UK Tobacco Policy and Expenditure—An Overview. ASH, 2007.

http://newash.org.uk/files/documents/ASH_667.pdf

⁴⁸⁰ Godfrey, C. Parrott, S. Coleman, T. & Pound, E. The cost-effectiveness of the English smoking treatment services: evidence from practice. *Addiction*, 2005; 100(suppl.2), 70–83.

⁴⁸¹ Chesterman, J. Judge, K. Bauld, L & Ferguson, J. How effective are the English smoking treatment services in reaching disadvantaged smokers? *Addiction*, 2005; 100 (Suppl.2), 36–45.

⁴⁸² OPCS 1996.

⁴⁸³ Ashworth, M. Armstrong, A. The relationship between general practice characteristics and quality of care: a national survey of quality indicators used in the UK Quality and Outcomes Framework, 2004–5. *BMC Family Practice* 2006, 7:68doi:10.1186/1471-2296-7-68.

⁴⁸⁴ Brief interventions and referral for smoking cessation in primary care and other settings. Public Health Intervention Guidance no.1. NICE. March 2006. <http://www.nice.org.uk/page.aspx?o=PHI001>

BRIEF INTERVENTIONS AND THE QOF

17. Over 80% of the population visit GPs at least once a year and the figure is higher for smokers.⁴⁸⁵ But QOF scores show that socially deprived areas receive a lower quality of primary care and that social deprivation is an independent predictor of lower quality.⁴⁸⁶ Brief advice by doctors is effective in reducing patients' smoking and NICE guidance has been issued on this topic last year.⁴⁸⁷ GP practices should all be advising smokers to quit and referring them to Stop Smoking Services where appropriate, but this is only happening in a minority of cases.^{488, 489}

18. The QOF currently awards 41 of the 74 points available for smoking for simply recording smoking status. The remaining 33 points are awarded for giving smoking cessation advice only to patients in specific disease categories by which time it may well be too late.

19. Together with the Royal College of Physicians and the Royal College of General Practitioners ASH recommended that the QOF be rebalanced using the existing points to award most of these points to doctors for ensuring that 90% of all smokers were given smoking cessation advice and referred to stop smoking services at least once every fifteen months, with less for simply recording smoking status, but our proposals were not accepted.

20. *Recommendation:* The QOF is currently being renegotiated again, and the HSC should also call for a rebalancing of points awarded to prioritise smoking cessation advice and referral.

SMOKING CESSATION IN HOSPITALS

21. More also needs to be done to enable patients to access smoking cessation advice and services from secondary care. For example, smoking cessation is the only intervention that changes the natural history of chronic obstructive pulmonary disease (COPD) or reduces the risk of lung cancer, but only half of all UK chest specialists have direct access to a Stop Smoking counsellor.⁴⁹⁰

22. In addition health professionals in hospitals are not making best use of existing services. A survey in one hospital found that while 20% of inpatients smoked, less than a third were given smoking cessation advice, despite the hospital having a smoking cessation service.⁴⁹¹ Furthermore while there were high levels of awareness amongst health professionals of the local Stop Smoking Service in a District General hospital, only one in five had referred smokers to the service.⁴⁹²

23. We have been told that in some PCTs there are problems for hospitals in developing smoking cessation services, because PCTs are concerned that smokers quitting in hospitals won't count towards their quit targets.⁴⁹³

24. *Recommendation:* That the HSC should examine why it is that smoking cessation is not routinely provided in hospitals and what can be done to remedy this situation.

THE NHS AND LOCAL AUTHORITIES

25. The NHS needs to collaborate with Local Authorities in order to be most effective in helping reduce health inequalities and smoking prevalence should be one of the areas specifically targeted. In the North-West of England local authorities and PCTs have collaborated effectively to reduce smoking prevalence, particularly in Liverpool⁴⁹⁴, and the North-East has an innovative model with PCTs funding their own regional office of tobacco control⁴⁹⁵, which has also been very effective.

26. ASH and the Chartered Institute of Environmental Health have developed a briefing note for local authorities on how Local Area Agreements can be used to reduce smoking prevalence and tackle health inequalities.⁴⁹⁶ CIEH, the Faculty of Public Health, the Trading Standards Institute and the Association of

⁴⁸⁵ OPCS 1996.

⁴⁸⁶ Ashworth, M. Armstrong, A. The relationship between general practice characteristics and quality of care: a national survey of quality indicators used in the UK Quality and Outcomes Framework, 2004–5. BMC Family Practice 2006, 7:68doi:10.1186/1471-2296-7-68.

⁴⁸⁷ Brief interventions and referral for smoking cessation in primary care and other settings. Public Health Intervention Guidance no.1. NICE. March 2006. <http://www.nice.org.uk/page.aspx?o=PH1001>

⁴⁸⁸ Coleman T, Wynn A, Barrett S, Wilson A. Discussion of NRT and other antismoking interventions in UK general practitioners' routine consultations. Nicotine and Tobacco Research 2003;5:163–8.

⁴⁸⁹ Taylor, T. Lader D. Bryant, A. Keyse, L. McDuff, TJ. Smoking related behaviour and attitudes, 2005. London: Office for National Statistics, 2006.

⁴⁹⁰ Campbell, I. A., Lewis, K. E., and Preston, L. A. Surveys and assessment of secondary care smoking cessation services in the UK, 2001–2003. Thorax 2003;53 (Suppl III):iii42–iii43(Abstract).

⁴⁹¹ Warner, A *et al.* Smokers admitted to hospital: Role of junior doctors, smoking cessation services and smoke-free hospital. BTS winter conference 2006.

⁴⁹² Elsheikh, A. The NHS Stop Smoking Services: Hospital staff awareness and the pattern of referral to the local (Basildon and Thurrock) Services. BTS winter conference 2006.

⁴⁹³ Personal communication from Medical Director of a large teaching hospital.

⁴⁹⁴ See submission to HSC Inquiry from Smokefree North West.

⁴⁹⁵ For more information contact Fresh North-East <http://www.freshne.com/>.

⁴⁹⁶ CIEH ASH briefing paper on Local Area Agreements and smoking prevalence http://newash.org.uk/files/documents/ASH_673.pdf

Directors of Public Health sent this briefing note to all Regional Directors of Public Health and local authorities and encouraged them to ensure that Local Strategic Partnerships adopt smoking prevalence as one of the stretch targets in their Local Area Agreements and work together to develop action plans.⁴⁹⁷

POPULATION LEVEL MEASURES

27. There is evidence from jurisdictions with strategic tobacco control frameworks, such as California and Australia, on how to bring smoking prevalence down and such measures are both inexpensive and highly cost-effective compared to health interventions to treat disease once it has developed. Population measures rather than measures targeted at individual subgroups have been found to be particularly effective.

28. There is also good evidence that smoking prevalence only continues to go down when all policy levers continue to be used to the full.^{498, 499, 500}

TAXATION AND SMUGGLING

29. The most effective means of reducing smoking prevalence is price increases through tobacco taxation, which is also most effective with poorer and younger smokers.^{4, 5}

30. HM Treasury has made clear that it does not believe that increasing taxation on tobacco products is a lever it can use at the present time given the continuing high levels of smuggling. Reducing smuggling therefore is a priority.⁵⁰¹ It is also crucial to reducing health inequalities as less affluent smokers are more likely to use contraband tobacco.⁵⁰²

31. While much has been done to tackle smuggling, further measures are needed. In particular we would like to see the government actively supporting a strong global protocol to the WHO Framework Convention on Tobacco Control, as set out in the WHO expert working group's template, which was agreed by the last Conference of the Parties as a basis for the negotiations due to start shortly. We would also like to see strong support for the timetable which envisages the protocol being put to the Conference of the Parties for adoption in 2010. Smuggling is a global problem and requires a global solution.

32. Furthermore we would like to see the UK signed up to the anti-smuggling Agreements that the European Commission and all other EU Member States have signed with Philip Morris International (PMI) and Japan Tobacco International (JTI), two of the top three tobacco companies in the world.^{503, 504} As a non-signatory the UK will not benefit from Agreements which ensure that both companies are required to control the illicit trade in their products and to pay heavily if their cigarettes continue to be smuggled.

33. The UK refused to sign the PMI agreement, arguing that as PMI only had a small market share in the UK, it was not relevant. This argument will not wash with Japan Tobacco, which recently acquired UK-based Gallaher, the UK's second-largest tobacco company. With an almost 40% market share, JTI has a significant stake in, and control over, the UK tobacco trade.⁵⁰⁵ (Gallaher will fully join up to the Agreement in two years, but the general compliance obligations apply immediately).

34. In 2005–06 of the 2 billion smuggled cigarettes seized by Customs, about 200 million were Gallaher brands, making them the UK brand with the biggest share of the smuggled cigarette market. If the JTI agreement had been fully in force at that time, the UK would have received over £100 million in seizure payments from Gallaher.⁵⁰⁶

35. ASH is calling on the Government to urgently reappraise its strategy on smuggling and sign the EU accords with PMI and JTI.

36. HM Treasury reduced VAT on nicotine replacement products from 17.5% to 5% for one year from 1 July 2007, to encourage more smokers to quit. Research carried out for ASH shows that the reduction in tax has transferred through to the retail price and there seems to have been a positive impact on sales, although there are a number of confounding factors.⁵⁰⁷ We would therefore like to see the Treasury sustain this reduction in taxation of such products permanently in the next budget.

⁴⁹⁷ ASH press release 3rd December, 2007 + links to documents http://www.newash.org.uk/ash_be2td0a.htm

⁴⁹⁸ Hill DJ *et al.* Smoking behaviours of Australian adults in 1995: trends and concerns. *Med J Aust* 1998; 168: 209–213. <http://www.mja.com.au/public/issues/mar2/hill/hill.html>

⁴⁹⁹ Tobacco Control journal supplement : 2003; 12 Supplement ii.

⁵⁰⁰ Pierce, J *et al.* Has the California Tobacco Control Program Reduced Smoking? *JAMA*. 1998;280:893–899.

⁵⁰¹ PSA 18 Delivery Agreement 3.15

http://www.hm-treasury.gov.uk/media/5/A/pbr_csr07_psa18.pdf accessed on 5 January 2008

⁵⁰² Chief Medical Officer. Annual Report of the Chief Medical Officer on the State of Public Health. London: Department of Health; 2005.

⁵⁰³ Details of the EU Agreement with JTI accessed 8 January 2008

http://ec.europa.eu/anti_fraud/budget/cig_smug/2007_en.html

⁵⁰⁴ ASH press release 9 July 2004 & briefing note. <http://www.newash.org.uk/html/press/040709brief.html>

⁵⁰⁵ ASH Briefing on Gallaher and Japan Tobacco International. http://newash.org.uk/ash_4oup4ckq.htm

⁵⁰⁶ This is based on HMRC estimates that in 2005–06 2 billion cigarettes were seized. Of these, 18% were genuine UK brands. Gallaher brands accounted for 49% of these brands (ie around 9% of the total). 100% of tax and duties owed on the first 90 million and 500% thereafter at £3.91 per pack in 2005–6 see Tobacco Factsheet table 3.3

<http://www.uktradeinfo.com/index.cfm?task=facttobac>

⁵⁰⁷ This report for ASH is currently being finalised.

SOCIAL MARKETING

37. Mass media interventions are expensive but highly cost-effective on a per capita basis. Paid mass media advertising campaigns have been found to be an effective means of reducing smoking^{508, 509, 510}, and can be targeted to be specifically aimed at lower socio-economic groups to tackle health inequalities, but they need to be sustained and have high impact. Such campaigns can also reduce incident smoking in young people.⁵¹¹

38. Mass media campaigns are also needed to continue to address smoking in the home and other private places such as cars. This remains the major source of secondhand smoke exposure, and those from disadvantaged backgrounds, particularly children, are worst affected.⁵¹² Self-enforced restrictions on smoking at home are effective in reducing exposure to children but are currently imposed by less than 20% of households.⁵¹³

39. Mass media campaigns are also a necessary and very effective driver of smokers to the Stop Smoking Services. This is illustrated by what happened in the second quarter of 2006 when the campaigns were stopped. Without the impetus of mass media to encourage people to quit, the number of successful quitters through the services fell by 17% from the same quarter in the previous year, from 76,000 in April to June 2005 to only 66,000 in April to June 2006.

**Comparison of mass media spend on smoking campaigns in England
between 2004–5 and 2005–6 in £ millions**

	Q4 Oct–Dec	Q1 Jan–Mar	Q2 Apr–Jun	Q3 Jul–Sept	Total
2004–5	4.7	6.9	4.9	6.6	23.1
2005–6	3.4	5.5	0.0	3.0	11.9

Source: COI.

40. As the table above shows, it was not just that the media spend in that quarter fell to nothing, but also that the media spend in the previous two quarters was more than a third down on the previous year. The level of spend on the services is believed to have remained fairly consistent year on year over this period.¹⁶

41. The conclusion of numerous studies of mass media campaigns has been that the key to success was maintaining a consistent and sustained level of advertising over time.^{514, 515, 516, 517} This is hardly surprising, since given this is the lesson of commercial advertising, why should it be any different for social marketing?

42. The US Centers for Disease Control has put together recommendations for spend on mass media campaigns, based on the spending levels in the four states which had effective tobacco counter-marketing campaigns which had been successful in changing both attitudes and behaviours. CDC recommended a spend of between \$1–3 a year per capita. The CDC mid-range recommendation of \$2 per capita would give an annual spend of £50 million p.a.

43. However, since 2004–5 the level of spend has fallen, to £22.7 million in 2005–6 and £13.5 million in 2006–7. DH may argue that money is being allocated locally to target key groups of smokers more effectively, and so tackle health inequalities. We would argue that this should be in addition to mass media spend and not as an alternative.

⁵⁰⁸ Reid DJ, Killoran AJ, McNeill AD, Chambers JS. Choosing the most effective health promotion options for reducing a nation's smoking prevalence. *Tobacco Control* 1992;1:185–97.

⁵⁰⁹ Hill DJ, White VM, Gray NJ. Australian patterns of tobacco smoking in 1989. *Med J Aust.* 1991;154:797–801.

⁵¹⁰ Department of Health Economics and Operational Research Division. Effect of tobacco advertising on tobacco consumption: a discussion reviewing the evidence. London: Department of Health, 1992.

⁵¹¹ Siegel M., Biener L. The impact of an antismoking media campaign on progression to established smoking: results of a longitudinal youth study. *Am.J Public Health* 2000;90:380–6.

⁵¹² Going smoke-free: The medical case for clean air in the home, at work and in public places. A report on passive smoking by the Tobacco Advisory Group of the Royal College of Physicians. London July 2005. Available at: <http://www.rcplondon.ac.uk/pubs/brochure.aspx?e=4>

⁵¹³ Blackburn C, Spencer N, Bonas S, Coe C, Dolan A, Moy R. Effect of strategies to reduce exposure of infants to environmental tobacco smoke in the home: cross sectional survey. *Brit.Med.J.* 2003;327:257–60.

⁵¹⁴ Hyland *et al.* Anti-tobacco television advertising and indicators of smoking cessation in adults: a cohort study. *Health Education Research*, 2005.

⁵¹⁵ McVey D., Stapleton J. Can anti-smoking television advertising affect smoking behaviour? Controlled trial of the Health Education Authority for England's anti-smoking TV campaign. *Tobacco Control* 2000;9:273–282.

⁵¹⁶ Erbas B. *et al.* Investigating the relation between placement of Quit antismoking advertisements and number of telephone calls to Quitline: a semiparametric modelling approach. *Journal of Epidemiological Community Health* 2006;60:180–182.

⁵¹⁷ Levy D. and Friend K. A Computer Simulation Model of Mass Media Interventions Directed at Tobacco Use. *Preventive Medicine* 32, 284–294 (2001).

HARM REDUCTION

44. The Government have committed to consult on a harm reduction strategy for tobacco control. It's the tobacco smoke that kills people not the nicotine. While the gold standard should always be quitting, a harm reduction strategy should give smokers, in particular the most disadvantaged who find it harder to quit, access to less harmful forms of nicotine in a form and at a price that is attractive as an alternative to smoking. This must be accompanied by effective marketing so that people understand that it is not the nicotine itself that is harmful but that the harmfulness of delivery varies greatly.

45. A switch of only 1% of the population a year from smoking to less harmful nicotine sources, a conservative target, would save around 60,000 lives in only 10 years.⁵¹⁸

OTHER MEASURES

46. Also necessary are:

- A comprehensive three year review of the smokefree legislation and revision of the regulations where necessary;
- Development of a strategy for tackling smoking in private places such as the home and the car;
- Strengthening of restrictions on residual marketing for example a complete ban on point of sale advertising, and generic packaging for all tobacco products;
- A ban on vending machine sales of cigarettes;
- Introduction of positive licensing for retailers.

TARGETS

47. Reducing inequalities in smoking rates is crucial to a reduction in health inequalities as is recognised in the DH PSA target on smoking which is "Reducing smoking rates to 21% or less by 2010, with a reduction in prevalence among routine and manual groups to 26% or less."

48. On current estimates smoking prevalence is declining by about 0.4% per annum.⁸ Overall smoking prevalence in 2005 was 24%, with smoking rates amongst routine and manual workers still at 31% and no sign of the differential being eroded. At current rates of decline smoking prevalence among routine and manual workers is likely to be at around 29% in 2010, a full 3% above the target. Yet these are not ambitious targets and are nowhere near the "fully engaged scenario" envisaged by Wanless of 17% by 2010 and 11% by 2022.¹⁰

49. HMRC targets to reduce smuggling are also relevant to health inequalities and to reduction in smoking prevalence, as low income smokers are much more likely to smoke smuggled cigarettes.⁵¹⁹ Currently (taking the mid-point) smuggled cigarettes have a market share of 14.5%, but it is still the case that over 50% of hand-rolled tobacco (HRT) consumed in this country is smuggled.⁵²⁰ This is of particular concern as HRT is most popular with routine and manual male smokers (42% of men in routine and manual occupations mainly smoke HRT, compared to only 25% of the population as a whole⁵²¹).

50. The current PSA targets are⁵⁴:

By 2007–08:

- reduce the illicit market share for cigarettes to no more than 13%;
- A new, specific operational target for HRT announced in March 2006 of reducing the size of the UK illicit market by 1,200 tonnes—equivalent to around 20 per cent.

The target for cigarettes is achievable, but new, stretching targets need to be set for the future. Despite the new strategy for tackling smuggling of HRT, the target for HRT is unlikely to be reached.

51. ASH was therefore concerned to hear when we met with the Minister Angela Eagle at the end of last year that new PSA targets for HM Revenue & Customs to reduce tobacco smuggling will not be set after the current targets expire at the end of this financial year. She stated that this is only a "definitional issue" as reducing smuggling will be a Departmental Strategic Objective, but unless specific targets are published, our view is that there will not be clarity about what HMRC is expected to achieve. It is also crucial that HMRC continue to collect and publish the information about the outcomes, in other words the estimated range of illicit market shares of both the cigarette market and the hand-rolled tobacco market and specific details about the breakdown of the market.

⁵¹⁸ Lewis S. Arnott D. Godfrey C. Britton J. Public health measures to reduce smoking prevalence in the UK; how many lives could be saved? *Tobacco Control* 2005; 14:251–254.

⁵¹⁹ Chief Medical Officer. Annual Report of the Chief Medical Officer on the State of Public Health. London: Department of Health; 2005.

⁵²⁰ HMRC Departmental Report Integrating and growing stronger Spring 2007
http://customs.hmrc.gov.uk/channelsPortalWebApp/downloadFile?contentID=HMCE_PROD1_027505

⁵²¹ Statistics on Smoking: England, 2007. The Information Centre 2007.

52. *Recommendation:* That the HSC call Angela Eagle, Exchequer Secretary to the Treasury who is responsible for HMRC to give evidence to the Inquiry about the government's tobacco smuggling strategy and targets.

January 2008

Appendix 1

DEATHS CAUSED BY SMOKING

1. One in two long-term smokers will die prematurely as a result of smoking—half of these in middle age. One quarter will die after 70 years of age and one quarter before, with those dying before 70 losing on average 21 years of life.⁵²² It is estimated that between 1950 and 2000 six million Britons died from tobacco-related diseases.⁵²³

2. The most recent estimates show that around 114,000 people in the UK are killed by smoking every year, accounting for one sixth of all UK deaths.⁵²⁴ This is more than three times the number of deaths from obesity, the second major cause of ill-health and premature death.⁵²⁵ The table on the next page shows the percentage and the number of deaths attributable to smoking by type of disease, based on the latest available breakdown (2002 data).

3. Deaths caused by smoking are five times higher than the 22,833 deaths arising from: traffic accidents (3,439); poisoning and overdose (881); alcoholic liver disease (5,121); other accidental deaths (8,579); murder and manslaughter (513); suicide (4,066); and HIV infection (234) in the UK during 2002.⁵²⁶ For more on deaths from smoking in the UK and worldwide see: www.deathsfromsmoking.net

4. Smoking also causes or exacerbates many other conditions, which even if they are not deadly can cause years of disease and distress. For example fertility is 30% lower in female smokers. See table for a detailed breakdown.

**Estimated percentages and numbers of deaths attributable to smoking in the UK by cause
(based on 2002 mortality data)^{527, 528}**

	Deaths from disease estimated to be caused by smoking			% of all deaths		
	Men	Women	Total	Men	Women	Total
<i>Cancer</i>						
Lung	18002	10032	28034	89	75	84
Upper respiratory	525	85	610	74	50	66
Oesophagus	3248	1743	4991	71	65	68
Bladder	1521	318	1839	47	19	37
Kidney	788	72	860	40	6	27
Stomach	1385	266	1651	35	11	26
Pancreas	670	923	1593	20	36	23
Myeloid leukaemia	264	131	395	19	11	15
All Cancers	28000	14800	42800	36	21	29
<i>Respiratory</i>						
Chronic obstructive pulmonary disease	13193	10685	23878	86	81	84
Pneumonia	3162	2900	6062	23	13	17
<i>Circulatory</i>						
Ischaemic heart disease	14182	6361	20543	22	12	17
Cerebrovascular disease	3064	3764	6828	12	9	10
Aortic aneurysm	3652	1939	5591	61	52	57
Myocardial degeneration	6670	2936	9606	22	12	15
Atherosclerosis	63	56	119	15	7	10

⁵²² Peto R. Mortality in relation to smoking: 40 years' observations on male British doctors. *BMJ* 1994; 309: 901–911.

⁵²³ Peto R *et al.* Mortality from smoking in developed countries, 1950–2000. Oxford Medical Publications, 1994.

⁵²⁴ Peto R *et al.* Mortality from smoking in developed countries, 1950–2000 (2nd edition). Oxford University Press, Oxford. View report.

⁵²⁵ National Audit Office. Tackling Obesity in England. Report of the Comptroller and Auditor General, Feb 2001. View press notice.

⁵²⁶ Mortality statistics 2002., Office for National Statistics, 2002; General Register Office for Scotland 2002; Registrar General Northern Ireland, Annual Report, Statistics & Research Agency, 2002.

⁵²⁷ Nicotine Addiction in Britain. A report of the Tobacco Advisory Group of the Royal College of Physicians. RCP 2000 (for percentage of smoking-related deaths).

⁵²⁸ Mortality statistics 2002., Office for National Statistics, 2002; General Register Office for Scotland 2002; Registrar General Northern Ireland, Annual Report, Statistics & Research Agency, 2002.

	Deaths from disease estimated to be caused by smoking			% of all deaths		
	Men	Women	Total	Men	Women	Total
<i>Digestive</i>						
Ulcer of the stomach or duodenum	907	1008	1915	45	45	45
Total caused by smoking	71,296	43,219	114,597			
<i>Preventable by smoking</i>						
Parkinson's	1369	549	1918	55	28	43
Cancer of endometrium		260	260		17	17
Total prevented by smoking*	1369	809	2178			
Deaths from all causes due to smoking (causes less prevented)	69,927	42,210	112,337			

* Studies have shown that smoking appears to have a protective effect against the onset of some diseases such as endometrial cancer. However, the positive effect is so small compared to the overwhelming toll of death and disease caused by smoking that there is no direct public health benefit.

Diseases caused by, or made worse by smoking⁵²⁹

Disease is more persistent or severe in smokers	Common cold Crohn's disease (chronic inflamed bowel) Influenza	Tuberculosis Asthma (symptoms are worse in smokers)
Symptoms worse in smokers	Chronic rhinitis (inflammation of nose) Diabetic retinopathy (eye disease) Graves' disease (over-active thyroid gland)	Multiple sclerosis Optic neuritis
Function impaired in smokers	Fertility (30% lower in female smokers) Menopause (onset 1.74 years earlier on average) Reduced sperm count and motility, sperm less able to penetrate the ovum, increased shape abnormalities	Impotence Erectile dysfunction Ejaculation (volume reduced) The immune system is impaired.
Increased risk for smokers	<i>Diseases of the gums and teeth</i> Acute necrotizing ulcerative gingivitis (gum disease) Tooth loss <i>Stomach/digestive system</i> Duodenal ulcer Colon polyps Crohn's disease (chronic inflamed bowel) Stomach ulcer <i>Skin</i> Psoriasis Skin wrinkling <i>Other</i> Depression Diabetes (type 2, non-insulin dependent) Hearing loss	<i>Heart and circulation</i> Angina Buerger's Disease (severe circulatory disease) Peripheral vascular disease <i>Ligaments, muscles and bones</i> Ligament, tendon and muscle injuries Neck and back pain Osteoporosis (in both sexes) Rheumatoid arthritis (for heavy smokers) ⁵³⁰ <i>Eyes</i> Cataract Cataract, posterior subcapsular Optic neuropathy (loss of vision) Ocular histoplasmosis (fungal eye infection) Macular degeneration Nystagmus (abnormal eye movements) Tobacco Amblyopia (loss of vision)

Memorandum by the Royal Pharmaceutical Society of Great Britain (HI 64)

HEALTH INEQUALITY

1. EXECUTIVE SUMMARY

This memorandum outlines how pharmacy can help the NHS to address and reduce health inequalities in England. Pharmacies are easily accessible and conveniently located. Pharmacists and their support staff provide a number of services that help to address the health inequality issue. The pharmacy profession needs to become integrated into the NHS at both a national and local level for its full potential to provide benefits to patients and the public can be realised.

⁵²⁹ Cigarettes: What the warning label doesn't tell you. American Council on Science and Health, 1997.

⁵³⁰ Hutchinson, D *et al.* *Annals of Rheumatic Diseases*, 2001; 60: 223-7.

2. INTRODUCTION

2.1 The Royal Pharmaceutical Society of Great Britain (RPSGB) is the professional and regulatory body for pharmacists in England, Scotland and Wales. It also regulates pharmacy technicians on a voluntary basis, which is expected to become statutory under anticipated legislation. The primary objectives of the Society are to lead, regulate, develop and represent the profession of pharmacy. The Society leads and supports the development of the profession within the context of the public benefit.

2.2 Our response focuses on the role that pharmacy, and in particularly community pharmacy, can play in helping to reduce health inequalities.

3.1 ACCESSIBILITY

3.1.1 A key aspect in addressing health inequalities is making services more accessible. Pharmacies are located where people live and work and are often open for extended hours, including evenings and weekends. A recent review by the Department of Health showed that 99% of people can get to a pharmacy within 20 minutes. Changes to the Control of Entry are possible outcomes of the forthcoming Government White paper on Pharmacy, as well as in Lord Darzi's NHS Next Stage Review. The RPSGB hopes that the possible effects of destabilising this pharmacy network and the effect on pharmacies' potential to address health inequalities are being considered.

3.1.2 Most of the new pharmacies that have opened up in the last two years have been in urban areas which are already well provided with health services. Pharmacists, like doctors, need to be encouraged to develop in deprived areas where there services are probably most required.

3.2 PUBLIC HEALTH

3.2.1 The Department of Health strategy "Choosing Health Through Pharmacy" clearly identifies and promotes the role that pharmacy could play in addressing health inequalities. Some of the activities that pharmacies provide to address this issue include:

- Signposting of patients to appropriate health services
- Stop smoking services
- Sexual Health services, such as Chlamydia screening and treatment, provision of emergency hormonal contraception
- Obesity advice and treatment
- Management of long-term conditions—for example diabetic monitoring and support
- Support services for drug misusers
- Minor ailment schemes and availability of medicines out of hours

3.2.2 Pharmacists are amongst the most visited of all NHS health service providers. This is particularly of benefit in addressing health inequalities as these visits are often by people not accessing the NHS through any other means. Figures show that the average adult visits a pharmacy 12 times a year. Pharmacy has a huge potential role therefore in helping to prevent and manage risks for coronary heart disease and cancer such as physical inactivity, diabetes and hypertension.

3.2.3 The new community pharmacy contract puts in place a framework to make use of this potential. By 2006 the contract had led to three-quarters of pharmacies installing private consultation areas, making a whole range of new clinical services available. However, pharmacy services are not being adequately commissioned, and where they are commissioned they need to be better integrated with mainstream primary community health services. The All Party Pharmacy Group report *the Future of Pharmacy* made clear earlier this year, that there is a postcode lottery of access to pharmacy services because local commissioners are not involving pharmacists in planning and delivering services local people want.

3.3 INTEGRATION

If the potential for pharmacy to deliver on health inequalities is to be met, a number of issues must be addressed. The financial and regulatory framework for community pharmacy must ensure that the existing pharmacy network is maintained, rationalised where appropriate and expanded where desirable. This will be particularly important if GP practices are amalgamated into a smaller number of centres and/or with the creation of polyclinics. Pharmacists must be accepted and developed as a full member of the local health team if their skills are to be effectively used to address health inequalities.

Primary care Trusts (PCTs) need to undertake a pharmaceutical needs assessment as part of the overall joint strategic needs assessment which will identify gaps in provision of pharmaceutical services.

4. EXPANDING ROLE

The role of pharmacists is expanding as more pharmacists take on advanced clinical roles such as independent and supplementary prescribing. Pharmacists with special interests in both the community and secondary care settings are developing.

5. CONCLUSION

In conclusion, and in answer to your first question, the RPSGB does believe that the NHS can help to reduce health inequalities. But it needs to have in place a system that makes best use of and consistently invests in the community based services it already has. This is not currently happening in community pharmacy.

January 2008

Memorandum by Alliance Boots (HI 65)

HEALTH INEQUALITIES

INTRODUCTION AND EXECUTIVE SUMMARY

Alliance Boots is Europe's largest pharmacy-led health and beauty group, created following the merger in 2006 of Alliance UniChem and Boots Group. We operate over 2,300 pharmacies across the UK, through our Boots stores.

This submission outlines how pharmacy contributes to tackling health inequalities, activity Boots is undertaking to help improve public health and the potential for pharmacy's role to be enhanced.

The extent to which the NHS can contribute to reducing health inequalities, given that many of the causes of inequalities relate to other policy areas eg taxation, employment, housing, education and local government;

1. Pharmacy is a core part of the NHS primary care family, providing medicines, healthcare services, information and advice to NHS patients and customers. At national campaign level, Change One Thing Schools is an example of a cross-cutting community initiative Boots is running in 2008. This free web-based resource for secondary school teachers is based on the Change One Thing New Year's health campaign, which for the third year running is helping thousands of Boots customers stick to their New Year's resolution. COT Schools bridges the gap between health and education, by encouraging 11–14 year olds to develop the skills to make healthy lifestyle choices, focusing on healthy eating; being active; and understanding the effects of smoking. This resource, which provides curricula-linked classroom activities and interactive action plans for pupils, is available to all secondary schools. Our pathfinder schools for the programme, for example, include a City Academy and a Special Educational Needs class, thereby improving health promotion in potentially hard-to-reach groups. As well as educating pupils in healthy choices from a young age, there could also be an impact on parents who may benefit from the information and skills their children are bringing home. COT Schools (www.bootschangeonethingschools.com) runs from early January and we aim to obtain feedback on improvements in the healthy choices and well-being of participating pupils.

The distribution and quality of GP services and their influence on health inequalities, including how the Quality and Outcomes Framework and Practice-based Commissioning might be used to improve the quality and distribution of GP services to reduce health inequalities;

2. A key strength of the Boots pharmacy offer is its accessibility, on high streets and in local communities. In areas where GP provision needs improving, Boots can be ideally placed to offer premises. We are currently engaged in PCT-led discussions in a number of locations across the country about the potential for hosting GP practices in over 100 stores. In Poole, Dorset we have worked in partnership with the PCT to establish an NHS Healthcare Centre, which is a satellite GP surgery, in our Boots store in the town shopping centre. This has been running since February 2007, with positive feedback from patients about the convenient location, transport links and facilities.

3. Limited out-of-hours access is a recognised problem with GP services. Pharmacy is ideally placed to plug this gap in healthcare provision. With evening and weekend opening hours, plus over 60 Boots Midnight Pharmacies and a 24-hour "Ask your Boots pharmacist" telephone helpline, patients have the reassurance of being able to access information, advice and treatment from a health professional. This can be particularly valuable in areas where GP out-of-hours provision is very limited.

4. There could be an opportunity to improve GP services in order to reduce health inequalities by linking more closely the contractual arrangements underpinning GP and pharmacy services. This could strengthen collaborative approaches to primary care provision and drive the development of clinical community pharmacy, shifting care further to communities for accessible and cost effective care. Where appropriate and where patients express a preference, this could involve some clinical tasks traditionally undertaken by the GP being transferred to the local pharmacy.

5. Greater collaboration between health professionals and more pharmacist involvement is also important for effective practice-based commissioning. The process would benefit from pharmacists joining practice-based commissioning teams where possible. In addition, as recommended by the All-Party Pharmacy Group's "*Future of Pharmacy*" report (June 2007), the Department of Health should provide guidance to PCTs and commissioning groups on how transparency and equity is to be achieved in practice-based commissioning.

The effectiveness of public health services at reducing inequalities by targeting key causes such as smoking and obesity, including whether some public health interventions may lead to increases in health inequalities; and which interventions are most cost-effective;

6. In 2006, Boots helped over 60,000 people to quit smoking through the NHS smoking cessation services on offer in our pharmacies. Patients could benefit more uniformly across the country from increased commissioning by PCTs of this Enhanced Service of the Pharmacy Contract. Our Change One Thing annual New Year's health campaign also helped 500,000 people to quit smoking in the same year. Our smoking cessation activity continues, and this year's Change One Thing campaign in stores and online (www.bootschangeonething.com) will also have a particular focus on achieving and maintaining a healthy weight. This national marketing approach, which provides customers with information, support and personalised action plans, has a broad reach to thousands of people, easily accessible on the high street and in local communities. Indeed Change One Thing was endorsed as the inspiration for the Government's "Small Change Big Difference" public health initiative, in the "*Partnerships for Better Health*" report published by the Department of Health in June 2007.

7. There are also best practice examples of pharmacy-led public health interventions at local level. In 2007–08, our UK wholesale business UniChem has been leading an obesity management pilot programme in association with Coventry Teaching Primary Care Trust, run in ten community pharmacies including Boots. The targeted programme, endorsed by the Department of Health, has since January 2007 been providing a weight management service for 150 patients in the Coventry area with a body mass index of 30 to 35 and at least one diagnosed or established risk factor (including hypertension, type-2 diabetes and increased waist circumference). The 12-month pilot scheme's objectives are to facilitate a weight loss of at least 5% in obese patients; identify obese patients at risk of developing long-term conditions; and educate patients in healthy living. Each patient attends eleven consultations over the twelve-month period, during which they are offered practical guidance and support tailored to individual need. We would be happy to provide details of the impact of the scheme once the pilot is over.

8. In providing drugs misuse and needle exchange services, pharmacies are also heavily involved in helping this group of individuals who are less likely to access the mainstream NHS, as well as playing a role in improving the wider community environment.

9. Sexual health is another public health issue that can be the result of local inequalities. The NHS London chlamydia screening pilot was launched in Boots stores in 2005, running until April 2008. It provides a free service for 16–24 year olds. Boots also runs its own national chlamydia screening service, available in over 1000 stores for a fee of £25 for a screen and £19 for treatment. 36% of those using the test kits to date have been male, a higher figure than the equivalent for the NHS service.⁵³¹ Availability of the service online may explain their relatively high uptake of the offer, with men traditionally less frequent users of health care.

The success of NHS organisations at co-ordinating activities with other organisations, for example local authorities, education and housing providers, to tackle inequalities; and what incentives can be provided to ensure these organisations improve care;

10. Variable PCT commissioning of Enhanced Services of the Pharmacy Contract is creating a fragmented system of postcode services across the country. This could be resolved if more pharmacy services were made available on a nationally defined and consistently available basis, shifting from the Enhanced to the Advanced tier of the Pharmacy Contract. Examples of such services include sexual health screening and advice; diabetes screening; and weight management. Pharmacy representation should be invited on all PCT professional executive committees (PECs).

⁵³¹ "*Delivering Faster Access to Better Care*", University of London School of Pharmacy, September 2007.

CONCLUSION

Community pharmacy recognises its responsibility to communicate clearly with PCTs. However, PCTs must also engage adequately with community pharmacy, which in many cases simply does not happen. We would like to see more local leadership at PCT level, expressing what they want and expect from pharmacy and thereby creating an environment in which those objectives can be met through collaborative working.

We hope to further enhance the public health promotion role of community pharmacy, including plugging gaps in provision in the areas with most need and being accessible to all patients and the public, including hard-to-reach groups.

January 2008

Memorandum by Asthma UK (HI 66)

HEALTH INEQUALITIES

KEY POINTS

- There are serious inequalities in health outcomes for people with asthma.
- The NHS can play a key role in reducing these through ensuring that people with asthma receive tailored information and joined-up care.
- People in deprived communities should be better supported to manage their condition through measures such as regular asthma reviews and the provision of written personal asthma action plans.
- Central and local government departments need to work together to develop cross-cutting strategies to address the roots of these problems.

1. ABOUT ASTHMA UK

1.1 Asthma UK is the charity dedicated to improving the health and well-being of the 5.2 million people in the UK whose lives are affected by asthma⁵³². We work together with people with asthma, health professionals and researchers to develop and share expertise to help people increase their understanding and reduce the effect of asthma on their lives.

1.2 Asthma UK is delighted to have the opportunity to respond to the Health Committee's inquiry on health inequalities. Inequalities in asthma incidence, treatment and outcomes are a key concern for the charity, and we are very pleased that the Committee is seeking to address these inequalities.

2. DEFINING THE PROBLEM

2.1 There are serious inequalities in health outcomes for people with asthma. Many of those experiencing the worst outcomes are also subject to other social and economic disadvantages. For example, South Asians are three times more likely and Afro-Caribbean people are twice as likely to have an emergency hospital admission for their asthma compared to the white population⁵³³.

2.2 Also, people based in North-West England (where there are high levels of Spearhead PCTs) were 65% more likely to be admitted to hospital than people in the East of England in 2004 and between neighbouring PCTs, emergency admission rates for asthma can differ by four times⁵³⁴. Differences are even more striking for children as the PCT with the highest admission rate admits almost ten times more under-15s than the PCT with the lowest rate⁵³⁵.

2.3 Asthma UK's opinion research has revealed that people from socio-economic categories D and E have significantly lower expectations of the outcomes of asthma treatment than others⁵³⁶ and are twice as likely as those from group A and B to expect asthma to make them compromise the way they live.

2.4 Those who need NHS and social care services the most are often the ones who fail to get the care they require, for example, through poor communication and follow-up after hospital admission or through a lack of specialists.

2.5 These negative health outcomes have broader consequences. Poor health can partially determine life chances, as well as being determined by them and long-term conditions can limit people's ability to work, or to learn. For example, over 12.7 million working days are lost to asthma each year, and almost a quarter

⁵³² Health Survey for England 2001.

⁵³³ Netuveli, G., Hurwitz, B., Levy, M., Fletcher, M., Barnes, G., Durham, S.R. & Sheikh, A. Ethnic variations in UK asthma.

⁵³⁴ Asthma UK, The Asthma Divide, 2007.

⁵³⁵ Unpublished data derived from hospital episode statistics 2004.

⁵³⁶ Asthma UK, National Asthma Panel, 2004.

of children with asthma miss at least six school days a year as a result of the condition. Social policies dealing with health, education, work and incomes should therefore be mutually reinforcing to address the roots of this problem.

3. HOW THE NHS CAN CONTRIBUTE TO REDUCING HEALTH INEQUALITIES

3.1 Inequalities in outcomes for people with asthma are likely to reflect endemic problems in the quality of the care provided throughout the system and as such, asthma treatment and outcomes can be used as a litmus test for the NHS. This is because asthma is a very common chronic condition which, for most people, can be manageable through effective primary care services relating to diagnosis, treatment, information and case management.

3.2 Below outlines Asthma UK's recommendations on how the NHS should be addressing this problem:

3.3 Targeted information:

People will not be empowered to better control their condition unless they have access to good information about their condition and about local health and social care services.

3.4 Ensuring that people can access this in formats appropriate to all ages and communities is key. In particular, Asthma UK has carried out some research into the kinds of information that older people with asthma would find most useful in order to inform one of our own projects. The greatest number (90%) would like to receive their information from their GP's practice, often directly from their own doctor. Similar research should be carried out with those communities who are not benefiting from the NHS and social care services that they need to ascertain how services might be tailored to better suit them.

3.5 Asthma UK provides information in a variety of formats and languages and we would like the Department of Health to adopt a similar approach. In some communities, change will only happen from within and not from a glossy website or brochure. Recent projects such as NHS Choices appear to be wholly web-based and such an approach might well widen inequalities.

3.6 Asthma UK is currently focusing its efforts to support the needs of people with asthma in deprived communities and is undertaking a Department of Health Information Prescriptions pilot with Hammersmith and Fulham PCT. The pilot, which ended in December and is currently being evaluated, regularly consulted people in this spearhead PCT, looking at issues such as the reading age of health promotion materials and access to specialist telephone support. This will ensure that patients—many of whom have English as a second language—can effectively access the support and information they need to take control of their condition.

3.7 Finally, patient groups are recognised as a trusted source of information. As such, Asthma UK calls upon the Government and the NHS to work more closely with patient groups to ensure that this information is accessible to those that could benefit most from it. This might include NHS Choices highlighting our literature on their site or NHS professionals more frequently offering or signposting patients to it.

3.8 Holistic care:

It is important that health and social care systems are able to address all of the conditions that a person has and not just focus on a particular condition to the detriment of others.

3.9 This is a particular issue for people from lower socio-economic backgrounds as people from social groups D and E are 1.5 times more likely to report having co-morbidities compared to people with asthma in all other social groups. Also, people with asthma who also have disabilities are far less likely to achieve international goals for treatment outcomes, which means that they are more likely to have asthma symptoms, more likely to experience limitations on their daily activities and are more likely to need reliever treatment.

3.10 To more effectively target health inequalities within these areas, the needs of people with multiple conditions must be better addressed. For example, evidence shows that long-term medical conditions may be overlooked if a patient also has a mental health condition and a recent regional study on asthma deaths has shown that in over 80% of cases, behavioural and psychosocial factors contributed to the patient's death, and the vast majority of these deaths may have been preventable⁵³⁷. The NHS needs to ensure that patients with complex needs have access to longer sessions with their healthcare professionals so that all of their needs can be fully addressed.

⁵³⁷ B Harrison, P Stephenson, G Mohan and S Nasser, An ongoing Confidential Enquiry into asthma deaths in the Eastern Region of the UK, 2001–2003, Primary Care Respiratory Journal, December 2005.

4. THE ROLE OF GP SERVICES AND THEIR INFLUENCE ON HEALTH INEQUALITIES

4.1 Improvements in services for people with asthma from the point of diagnosis and all along the care pathway could have real benefits in reducing inequalities of outcome. Given the differences in health outcomes that are noted above, we would like the Government to be more proactive in supporting people in deprived communities to manage their condition through measures such as regular asthma reviews and the provision of written personal asthma action plans.

4.2 As an estimated 75% of emergency asthma admissions could be avoided, effective targeting of those who are more likely to have an emergency episode would be an effective use of government funds. This is particularly true as caring for people after an asthma attack costs the NHS 3.5 times more than caring for those whose asthma is well-managed.

4.3 Asthma UK would be keen to see the inclusion of written personal asthma action plans within the Quality and Outcomes Framework. This is a valuable tool in helping people to self-manage their asthma and keep it under control. Research has shown that people who do not have a written personal asthma action plan are four times more likely to be admitted to hospital as a consequence⁵³⁸.

4.4 Self-management education has been proven successful in a broad range of populations. UK studies^{539, 540} recruiting specifically from deprived populations have demonstrated that such techniques have reduced exacerbations and unscheduled GP consultations and A&E attendances, though sub-group analysis suggests that the effect may be less than in white European populations. This observation should focus attention on the need for individualised action plans, taking into account cultural and personal preferences as well as clinical need.

5. THE ROLE OF PUBLIC HEALTH SERVICES IN REDUCING INEQUALITIES

5.1 The health impact of smoking on asthma and other conditions is enormous: smoking reduces lung function, increases the risk of asthma attacks and can lessen the effectiveness of some asthma medicines. 82% of people with asthma tell us that smoke triggers their symptoms⁵⁴¹ and living with a smoker increases the risk of adult-onset asthma fivefold⁵⁴². The risk to children from smoking parents is also considerable. Smoking during pregnancy increases by 35% the risk of a baby being wheezy or having breathing difficulties⁵⁴³.

5.2 Whilst there has been a reduction in the number of smokers in England over the past few decades, there has not been a significant change in the prevalence of smoking for people on lower incomes. This is clear when you compare the smoking prevalence among men in professional occupations (15%) to the smoking prevalence among men in unskilled manual occupations (42%)⁵⁴⁴. As such, Asthma UK considers it essential that the Government develops a comprehensive tobacco control strategy which focuses on the needs of those in the most deprived communities.

5.3 Obesity is also a public health concern that disproportionately affects people from deprived communities⁵⁴⁵ and people with asthma as people who are obese are 50% more likely to have asthma⁵⁴⁶. It is therefore essential that people are supported to be physically active by healthcare professionals as a part of their asthma management.

5.4 This can be a particular issue for children as around one-third of children with asthma miss out on PE and sports about once a week because of their condition, despite the fact that most should be able to take part as long as their asthma is under control. Asthma UK calls upon the Department of Health and the Department for Children, Schools and Families to address the specific needs of children and young people with long-term conditions to ensure that they are encouraged and supported to participate fully in physical activity.

⁵³⁸ Adams RJ, Smith BJ, Buffin RE, "Factors associated with hospital admissions and repeat emergency department visits for adults with asthma". *Thorax*, 2000, 55: 566–73.

⁵³⁹ Griffiths C, *et al*. Specialist nurse intervention to reduce unscheduled asthma care in a deprived multiethnic area: the east London randomised control trial for high risk asthma. *BMJ* 2004;328: 144–7.

⁵⁴⁰ Moudgil H, *et al* Asthma education and quality of life in the community: a randomised controlled study to evaluate the impact on white European and Indian subcontinent ethnic groups from socioeconomically deprived areas in Birmingham, UK *Thorax* 2000; 55: 177–183.

⁵⁴¹ Asthma UK, National Asthma Panel, 2004.

⁵⁴² Jaakkola MS, Piipari R, Jaakkola N, Jaakkola JJ. Environmental tobacco smoke and adult-onset asthma: a population-based incident case-control study. *Am J Public Health*. 2003 Dec; 93 (12): 2055–60.

⁵⁴³ Jaakkola JJ, Gissler M. Maternal smoking in pregnancy, foetal development and childhood asthma. *Am J Public Health* 2004 Jan; 94 (1): 136–40.

⁵⁴⁴ Department of Health, 2000.

⁵⁴⁵ Kinra, S., Nelder, R, Lewendon, G. *Epidemiol Community Health* 2000;54:456–460 (June). Deprivation and childhood obesity: a cross sectional study of 20 973 children in Plymouth, United Kingdom. Department of Public Health, South and West Devon Health Authority, Dartington.

⁵⁴⁶ Beuther DA, Sutherland ER "Overweight, obesity and incident asthma: a meta-analysis of prospective epidemiologic studies" *Am J Respir Crit Care Med* 2007 April 1 175 (7), 661–6; Flaherman V, Rutherford GW, "A meta-analysis of the effect of high weight on asthma" *Arch Dis Child* 2006 Apr; 91 (4), 334–9.

6. CROSS-GOVERNMENT ACTION TO ADDRESS ALL THE DETERMINANTS OF HEALTH INEQUALITIES

6.1 No one agency can address all of the factors contributing to health inequalities, so it is vital that different departments in national and local government work together to develop cross-cutting strategies to address the roots of these problems. Poor housing, pollution, poverty, disability, age and ethnicity all affect asthma outcomes, meaning that improvements will be limited without co-ordinated policies.

6.2 *Housing:*

Children living in damp, mouldy homes are 1.5 to three times more likely to experience coughing and wheezing⁵⁴⁷ and a recent Cardiff University study (partially funded by Asthma UK) found that removing indoor mould improved asthma symptoms. We recommend that national and local government liaise more effectively to improve the quality of existing housing.

6.3 *Air quality:*

Asthma UK would like the Government to prioritise improvements in indoor and outdoor air quality. Traffic fumes and other airborne pollutants can trigger asthma attacks and 66% of people with asthma tell us that their symptoms are worsened by traffic pollution. Valuable steps, such as the development of Low Emission Zones, are already being taken in parts of the UK and we would like such action to be adopted more widely.

6.3 *Children:*

Almost a quarter of children with asthma miss at least six school days a year as a result of the condition. Social policies dealing with health, education, work and incomes should therefore be mutually reinforcing to address the roots of this problem. Children and young people are among the most vulnerable to the effects of inequalities, so policies should be targeted to help them.

January 2008

Memorandum by the Royal College of Physicians (HI 67)

HEALTH INEQUALITIES

We are pleased to submit evidence to the above Inquiry. The Royal College of Physicians (RCP) plays a leading role in the delivery of high quality patient care by setting standards of medical practice and promoting clinical excellence. We provide physicians in the United Kingdom and overseas with education, training and support throughout their careers. As an independent body representing over 20,000 Fellows and Members worldwide, we advise and work with government, the public, patients and other professions to improve health and healthcare.

The following submission addresses the terms of reference 1–3 as set out by the committee, and is based on our work with the RCP Tobacco Advisory Group, and our work on alcohol, including with the Alcohol Health Alliance.

The consumption of cigarettes and alcohol are the two most important habitual and correctable causes of ill health in the UK. These factors disproportionately affect the most deprived members of our society and contribute to many thousands of avoidable deaths each year.

Our highest priority recommendations are to reduce the use of cigarettes and the consumption of alcohol in the most disadvantaged groups in our society. Our recommendations for actions to achieve these aims are:

- Appropriate incentives and targets must be set for smoking cessation services throughout primary and secondary care
- An increase in the development and delivery of smoking cessation services, including within secondary care and mental health institutions
- Cigarette pricing must be successively increased above the rate of inflation
- There must be a clamping down on smuggling and illicit “faghouse” sales

⁵⁴⁷ Peat JK, Dickerson J, Li J. Effect of damp and mould in the home on respiratory health: a review of the literature. *Allergy*. 1998, 53 (2): 120–128.

- Continued, sustained, varied, imaginative advertising and other social marketing campaigns to reduce motivation to smoke—in particular targeting disadvantaged groups
- There must be further constraints on the brand imagery, promotion and availability of cigarettes for sale—the implementation of generic plain packaging, removal of display gantries (making cigarettes an “under the counter” product), enforcing laws on sales to minors, removal of vending machines, licensing (positive or negative) of retail outlets
- Prevention of product placement and imagery in films, TV and other media—for example, by banning smoking in TV programmes shown before the 9pm watershed, and applying 18 classification to all new feature films featuring smoking
- A Nicotine Regulatory Authority must be established to oversee necessary changes to the nicotine product market
- Alcohol tax should be raised to provide adequate funding to bring alcohol treatment and prevention services up to the level of services provided for users of illegal drugs
- Targeted waiting times for alcohol treatment must be introduced
- The availability of alcohol must be reduced, particularly below-cost selling through supermarkets

1. *The extent to which the NHS can contribute to reducing health inequalities, given that many of the causes of inequalities relate to other policy areas eg taxation, employment, housing, education and local government;*

ALCOHOL

1.1 The misuse of alcohol in the UK is a major cause of health and social problems, with disadvantaged groups in society bearing a disproportionate brunt of the damage. The Department of Health programme for tackling health inequalities recognises that it is disadvantaged areas that particularly need improved alcohol misuse services⁵⁴⁸. The Royal College of Physicians working party report “Alcohol: Can the NHS Afford It?” (2001) estimated that the use of hospital facilities resulting from alcohol abuse places a considerable financial burden on the NHS, inpatient costs alone accounting for 2–12% of total NHS expenditure on hospitals.

1.2 The Prime Minister’s Strategy Unit (2003) estimated that the annual alcohol-related costs of crime and public disorder were put at £7.3 billion, workplace costs at £6.4 billion, and health costs at £1.7 billion. Around 17 million working days are lost annually due to alcohol abuse. Alcohol is responsible for 70% of deaths from liver cirrhosis. A report from the Chief Medical Officer (2001) stated that across both sexes and all age groups between 25 and 64, the annual mortality rate from chronic liver disease rose from 659 in 1970, to 3073 in 2000, a rise of 466%. This is at a time when deaths from chronic liver disease in Europe are falling.

1.3 A report from the Association of Public Health Observatories shows that lives lost, rates of mortality, admission to hospital, incapacity due to alcoholism, visits to a pub/bar and binge hazardous and harmful drinking all show much higher levels in the more deprived regions of England compared with the more affluent regions. It also shows this gap to be widening, with the effect on regional economies with proportions of the working population claiming incapacity benefits due to alcoholism⁵⁴⁹.

1.4 The most effective and cost effective strategy for reducing alcohol harm is to increase price and reduce availability⁵⁵⁰. Evidence suggests that increasing the price of alcohol could decrease alcohol related deaths⁵⁵¹, yet alcohol has become more than 50% more affordable in the last 25 years. In 2001 the Alcohol Harm Reduction Strategy for England found that alcohol causes 22,000 deaths, and the estimated cost of alcohol related harm to health, crime and the workplace was £15.4 billion—a figure which does not include human costs of crime, nor damage to families and children, which were felt to be incalculable.

1.5 In contrast the income from alcohol duty was £7 billion, with a further £6 billion in VAT⁵⁵². Raising overall alcohol related taxation would have the double benefit of reducing harmful levels of consumption, whilst providing more than enough funding for the exchequer, to bring alcohol treatment and prevention services up to the level of services provided for users of illegal drugs.

1.6 Given the current alcohol problem in the UK—to increase taxation on alcohol, and to improve treatment and prevention services seems both sensible and fair.

⁵⁴⁸ Department of Health. *Tackling health inequalities: a programme for action*. London: DoH, 2003.

⁵⁴⁹ Association of Public Health Observatories. *Indications of Public Health in the English Regions 8: Alcohol*. August 2007.

⁵⁵⁰ Academy of Medical Sciences. *Calling time—The nation’s drinking as a major health issue*. 3–1–2004. Academy of Medical Sciences, London.

⁵⁵¹ Anderson, P. and Baumberg, B. *Alcohol in Europe: A public health perspective*. 2007. EU Health and Consumer Protection Directorate General.

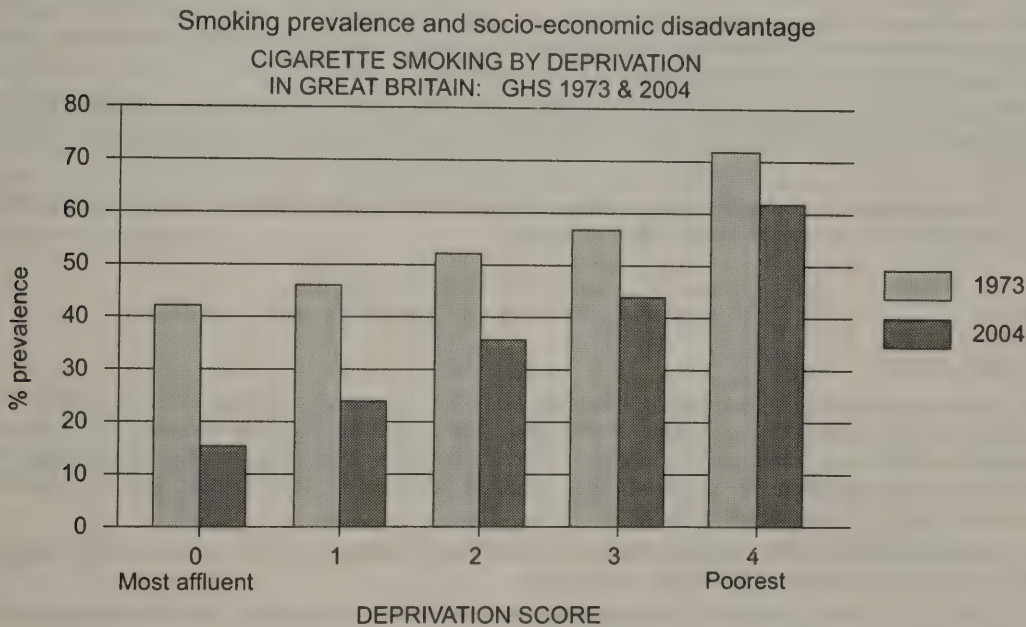
⁵⁵² Institute of Alcohol Studies. *Alcohol: Tax, Price and Public Health*. 2007.

SMOKING

Contribution of smoking to health inequalities

1.7 Smoking is the largest recognised cause of premature death and disability, and is responsible for about one in six deaths each year in the UK. Smoking causes a wide range of fatal and non-fatal diseases, the majority from three diseases: lung cancer, heart disease and chronic obstructive pulmonary disease. Smoking is especially prevalent among socially disadvantaged individuals, who are more likely to have grown up in a household with exposure to tobacco smoke, more likely to become smokers, more likely to start smoking at a very young age (when the brain is still developing, possibly leading to irreversible developmental changes leading to sustained nicotine addiction), likely to smoke more cigarettes per day, and to take more nicotine and tar from each cigarette than less disadvantaged smokers. Disadvantaged smokers are no less likely to want to quit smoking, or to use cessation services to help them to quit, but are less likely to succeed.

1.8 As a consequence, the most disadvantaged sectors of society have benefited least from the downward trend in smoking prevalence that has occurred over recent decades in the UK. As the figure below shows (data from the General Household survey, provided by Prof Martin Jarvis), smoking prevalence has fallen dramatically in the most affluent sectors of society over the past 30 years, but hardly at all among the most disadvantaged. Since smoking kills approximately half of all regular smokers, the persistence of such high smoking prevalence in the most deprived social groups has exacerbated health inequalities in the UK. Smoking is indeed the largest recognised avoidable cause of social inequalities in health¹. Reducing the prevalence of smoking among disadvantaged groups should be the highest priority in any strategy to reduce social inequalities in health.



2. The distribution and quality of GP services and their influence on health inequalities, including how the Quality and Outcomes Framework and Practice-based Commissioning might be used to improve the quality and distribution of GP services to reduce health inequalities;

SMOKING

2.1 As shown previously in this evidence, the NHS could achieve a great deal more in terms of identifying and intervening in smoking at individual level, and ensuring that cessation services are configured to deliver the necessary interventions in all healthcare settings. It is necessary to introduce measures that will ensure that all smokers have their smoking status identified at all health consultations, and help with cessation (behavioural support and pharmacotherapy) delivered if accepted. Recent changes to the Quality and Outcomes Framework have led to a substantial increase in the ascertainment of smoking status by primary care doctors, but little if any increase in intervention. In secondary care, consultants and junior staff who provide smoking cessation therapies and behavioural support for inpatients who smoke remain in the substantial minority. There are many reasons for this, but success in other areas (delivery of statin therapy to reduce cholesterol, for example) indicates that if the NHS prioritises this behaviour, it will occur. It is vitally important to set the appropriate incentives and targets to ensure that this happens throughout primary and secondary care.

2.2 As a further consideration it is also important to review the scope and targets set on cessation services, which tend at present to be configured (for entirely understandable and justifiable reasons) to deal with the largest numbers of smokers as efficiently as possible. Whilst this approach maximises the numbers of smokers treated overall, it also tends to abandon smokers for whom attendance at standard cessation services is difficult or impossible—those in secondary care or mental health institutions for example. At present, hospital trusts have no incentive or requirement to treat smokers in their care, and as a result, valuable opportunities to intervene at times when smokers are particularly susceptible to change, are being missed.

3. *The effectiveness of public health services at reducing inequalities by targeting key causes such as smoking and obesity, including whether some public health interventions may lead to increases in health inequalities*

ALCOHOL

3.1 Up to 12 million people in this country are dependent on alcohol or drink hazardously compared with 300,000 problematic drug users. Providing drug treatment for users of illegal drugs is a high government priority but there is comparatively little provision of treatment for alcohol related problems.

3.2 As a consequence, 67% of dependent or harmful drug users have access to treatment, compared with 5.7%⁵⁵³ for alcohol. The budget for the UK drug strategy in 2005–6 was £1,483 million⁵⁵⁴ but there is no dedicated budget for the UK alcohol strategy.

3.3 In addition to the absence of dedicated funding for alcohol treatment, there are no targeted waiting times for alcohol treatment and very few alcohol services for people with alcohol related chronic disease, many of whom do not have the features of alcohol dependence and as a result are under the radar of addiction services. In contrast the National Treatment Agency waiting time target for a Drug Intervention Program (DIP) is one week. Ensuring the provision of adequate treatment for adults and young people would significantly reduce the harm caused by alcohol misuse.

3.4 Furthermore, despite the wealth of evidence showing that early interventions in hazardous drinking are both effective and highly cost effective⁵⁵⁵, alcohol prevention strategies are unfunded and as a result very few exist.

3.5 Alcohol treatment and prevention programmes must therefore be properly funded to ensure that the gap in services in this area of public health is addressed.

SMOKING

Preventing smoking

3.6 Preventing smoking requires a combination of policies operating at population level that make smoking less easy, affordable, acceptable or even desirable to new and existing smokers, and policies at individual level that encourage existing smokers to quit. These two approaches work synergistically, since it is typically the population level policies that stimulate smokers to want to quit, and the individual approaches that are crucial to their success.

3.7 Policies that operate at population level to reduce the drivers to smoke (or “denormalise” smoking) tend to be outside the remit of the NHS, and include:

- Price—increasing the price of tobacco products decreases consumption, provided that alternative (ie smuggled or other illicit) sources of tobacco products are also closed off
- Mass media health promotion—high impact and varied advertising campaigns and other promotional activities that encourage smokers to quit, and young people to avoid starting
- Smoke-free policies—preventing smoking in public and in the workplace has a substantial impact on smoking prevalence.
- Banning all advertising and promotion of tobacco products

3.8 However, measures which operate at individual level to support cessation fall predominantly within the NHS remit, and involve:

- Systematic identification of smokers in all health consultations
- Individual promotion of smoking cessation to all smokers
- Provision of the most intensive cessation support with which smokers are likely to comply, to all who express a desire to attempt to quit (the more intensive the support used, the more likely the smoker is to succeed)
- Routine follow up and repeat intervention where appropriate

⁵⁵³ Alcohol needs assessment research project (ANARP). 2004. Department of Health.

⁵⁵⁴ Home Office: Drug Strategy: 2005–2006 funding, 2006.

⁵⁵⁵ Chisholm D, Rehm J, Van OM *et al*. Reducing the global burden of hazardous alcohol use: a comparative cost-effectiveness analysis. *J Stud Alcohol* 2004;65(6):782–93.

3.9 Over the past 10 years the UK government has made dramatic progress on almost all of the above measures, and deserves credit for doing so. However there is a great deal more that could be done (see below). There is also an unaddressed need to deal with the large numbers of smokers who will not, or are not capable of, quitting smoking in the short or medium term (see harm reduction, below).

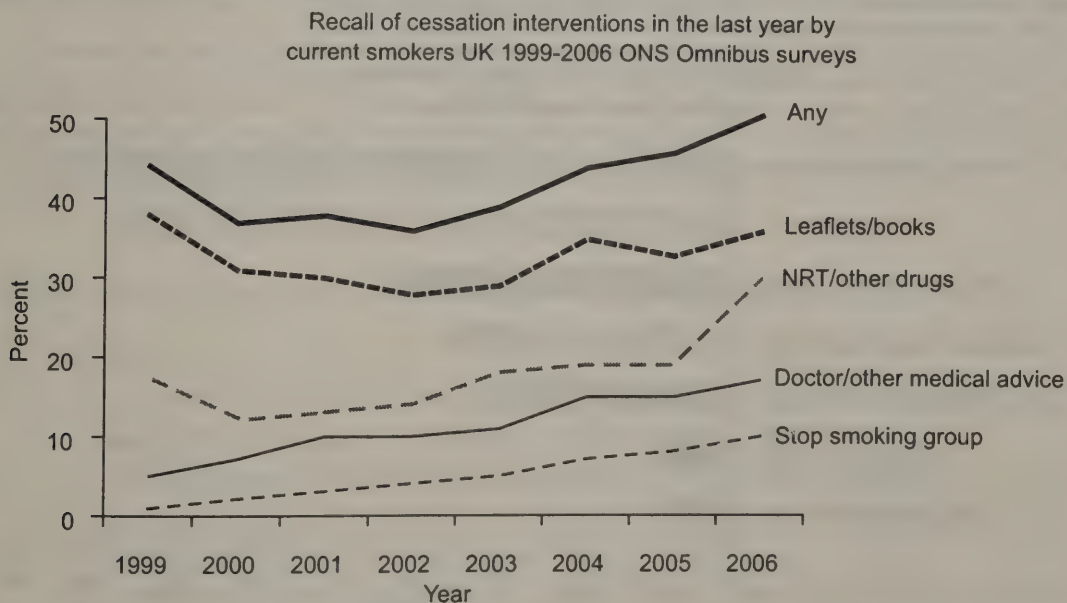
Further population measures required to reduce the prevalence of smoking

3.10 The following measures would help to denormalise smoking in the UK, and particularly among disadvantaged social groups, still further

- Successive increases in cigarette price above the rate of inflation
- Clamping down on smuggling and illicit “faghouse” sales
- Continued, sustained, varied, imaginative advertising and other social marketing campaigns to reduce motivation to smoke—in particular targeting disadvantaged groups
- Further constraints on the brand imagery, promotion and availability of cigarettes for sale—the implementation of generic plain packaging, removal of display gantries (making cigarettes an “under the counter” product), enforcing laws on sales to minors, removal of vending machines, licensing (positive or negative) of retail outlets
- Prevention of product placement and imagery in films, TV and other media—for example, by banning smoking in TV programmes shown before the 9pm watershed, and applying 18 classification to all new feature films featuring smoking

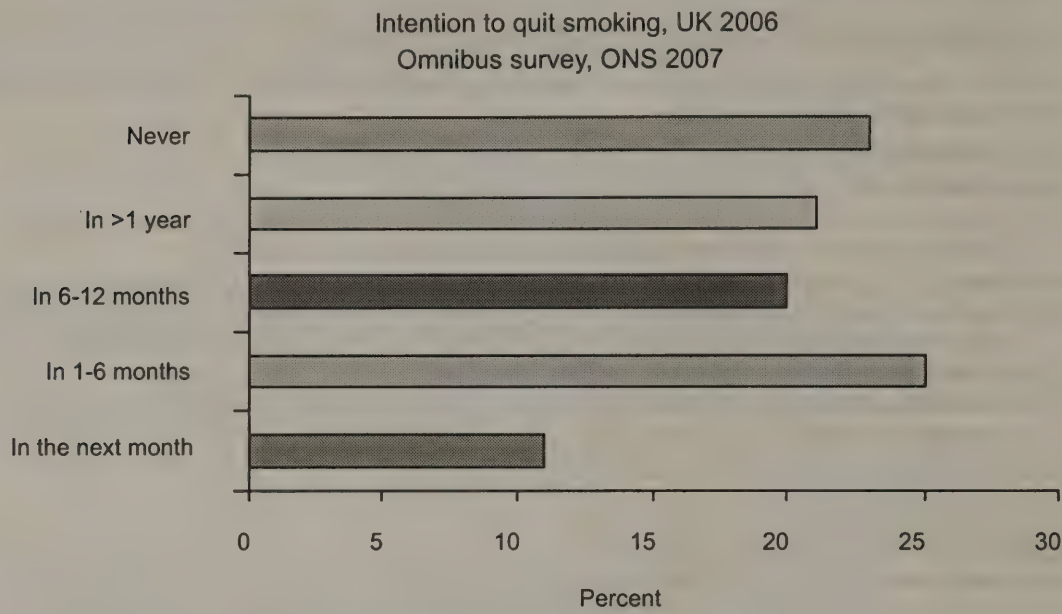
Further measures to improve cessation interventions

3.11 Development and delivery of smoking cessation services is very much within the NHS remit. The UK has led the world in development of cessation services, and the targeting of funds through the Health Action Zones was in particular crucial to establishing the foundation of that success. However, a great deal more could and should be done. According to successive Government Omnibus surveys, whilst the proportion of smokers accessing cessation services and using cessation therapies have increased progressively in recent years (see figure below), these proportions are still very small. In 2006 only 10% of smokers were referred to specialist cessation services; only 17% recall receiving advice from their doctor or other health professional.



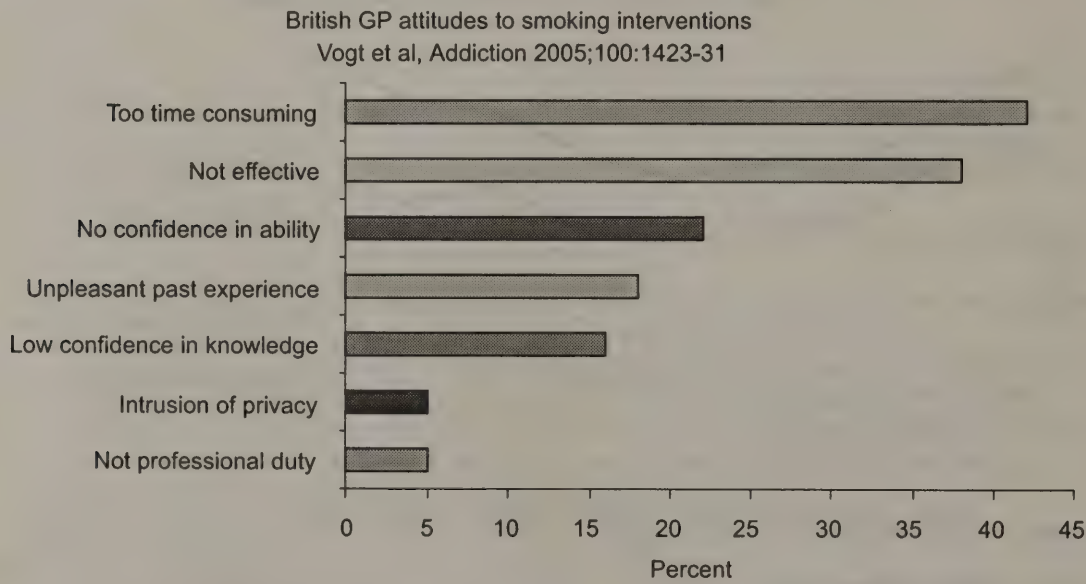
Source: ONS Omnibus surveys.

3.12 The improvement in these proportions is welcome, but smokers' reported desire to quit suggests that the figures could and should be much higher (see following figure). Whilst the reported proportions related to self-reported aspiration that may not in practice translate into action, they indicate that many more smokers might take up cessation services if properly approached and encouraged.



Source: Omnibus survey, ONS 2007.

3.13 There are several reasons why smoking cessation interventions have not been more widely used, and chief among them is a failure by health professionals to embrace smoking cessation to the extent it deserves, or indeed to the extent that they have embraced other preventive interventions. Doctors, nurses and other health professionals are still not trained to deliver smoking cessation interventions, and some do not see it as their job to do so (see figure):



Source: Vogt et al, Addiction 2005;100:1423-31.

3.14 The NHS could therefore achieve a great deal more in terms of identifying and intervening in smoking at individual level, and ensuring that cessation services are configured to deliver the necessary interventions in all healthcare settings. It is necessary to introduce measures that will ensure that all smokers have their smoking status identified at all health consultations, and help with cessation (behavioural support and pharmacotherapy) delivered if accepted. Recent changes to the Quality and Outcomes Framework have led to a substantial increase in the ascertainment of smoking status by primary care doctors, but little if any increase in intervention. In secondary care, consultants and junior staff who provide smoking cessation therapies and behavioural support for inpatients who smoke remain in the substantial minority. There are

many reasons for this, but success in other areas (delivery of statin therapy to reduce cholesterol, for example) indicates that if the NHS prioritises this behaviour, it will occur. It is vitally important to set the appropriate incentives and targets to ensure that this happens throughout primary and secondary care.

Harm reduction

3.15 Even with all of the above policies in place, many people, particularly from socially deprived groups, will continue to smoke. There are currently about 10 million smokers in the UK, and international experience indicates that it is unlikely that this figure can even be halved within the next 10–20 years. In other areas of medicine, harm reduction strategies are used widely to reduce the harm sustained by unhealthy behaviour, but this approach has not been implemented in smoking. There is a great deal that could be done in this area, with huge potential to benefit those smokers who are least likely to succeed in quitting, who are in turn those most addicted—that is, those from disadvantaged groups. These policies were outlined in a recent report from the RCP (*Harm reduction in Nicotine Addiction*; see <http://www.rcplondon.ac.uk/pubs/brochure.aspx?e=234>)².

3.16 The principle behind harm reduction strategies for smoking is that nicotine addiction, which is the main driver behind smoking behaviour, is not intrinsically harmful; it is the other constituents of cigarette smoke that kill. If smokers could be provided with safer sources of nicotine, preferably from pharmaceutical sources but possibly from other tobacco products, the harm they derive from nicotine consumption could be drastically reduced.

3.17 The measures we suggest involve radical changes to the current nicotine product market, in which cigarettes are currently the most available and least regulated products whilst medicinal nicotine is highly regulated and relatively inaccessible, to one in which the reverse applies—so that smokers are given strong incentives to switch from smoking to use alternative, less harmful sources of nicotine. We also advocate removal of some of the barriers to competition and development that currently inhibit the development of more effective cigarette substitutes. The fact is that the current system of legislative control on medicinal nicotine products, which is designed to protect the public, actually has the opposite effect through discouraging the development and marketing of innovative nicotine products.

3.18 The RCP report argues strongly that the status quo needs to change, and recommends the establishment of a nicotine regulatory authority to oversee the changes necessary. Some of the roles and functions of that authority are summarised in the table that follows.

We argue that the establishment of a Nicotine Regulatory Authority, with the necessary powers to implement the above functions, should be a high priority for the NHS and government. Implementing effective population and individual tobacco control measures will have a major impact on public health, and particularly on health inequalities. Whilst other aspects of health behaviour are undoubtedly important to address, none is more important to general health, or to the health of the most disadvantaged in society, than effective tobacco control.

SUGGESTED ROLES AND FUNCTIONS OF A NATIONAL NICOTINE REGULATORY AUTHORITY

Functions at initiation

- Baseline measurement of all current nicotine product use
- Ensure full implementation of conventional tobacco control policies (Box 1)
- Permissive licensing of medicinal nicotine products for use as smoking substitutes
- Substantial relaxation of restrictions on marketing and sale of medicinal nicotine products
- Removal of tax on medicinal nicotine products
- Communication of objective health risk information for nicotine products and promotion of harm reduction principles to smokers and the public
- Establishment of ground rules for monitoring the use of health messages in promoting the use of lower hazard nicotine products as substitutes for smoking
- Imposition of generic packaging for all tobacco products
- Prohibition of retail display of smoked tobacco products
- Strong graphic health warnings on smoked tobacco products
- Setting of tax and consequently retail price of all nicotine products in relation to their likely relative risk to health
- Prohibit all sale of nicotine products to individuals aged under 18

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- Introduce licensing of retailers of all smoked tobacco products
 - Assume responsibility for overseeing nicotine product delivery and toxicity monitoring
 - Mandate the introduction of reduced ignition propensity cigarettes
 - Take expert advice on how current restrictions on smokeless could be reformed to public health benefit

Continuing functions

- Regular monitoring of trends in nicotine product use, promotion and availability
- Monitoring impact of licensing and marketing relaxation on medicinal nicotine use, and revision as necessary to promote public health
- Progressive increases in tax on the most hazardous products
- Continued promotion of health information on different nicotine products and development and monitoring of mass communication strategies to prevent uptake, promote cessation, and reduce harm
- Progressive reduction in retail licenses for smoked tobacco products
- Monitoring and policing of illicit and underage tobacco and nicotine trade
- Work with the commercial sector to promote competition and innovation in the medicinal nicotine market
- Monitoring and prevention of smoked product placement and new methods of marketing (eg internet, viral marketing)
- Act on expert advice to set framework for licensing of low-hazard smokeless products and possible test marketing
- Progressively incentivise minority, high risk smokeless tobacco users to quit or else migrate to safer products
- Identify and respond to new developments or threats to health from new or existing product development or promotion
- Control of expenditure on tobacco control interventions to ensure evidence based and cost-effective interventions are used
- Support nicotine regulation and tobacco control approaches in resource-poor countries

January 2008

Memorandum by the British Dental Association (HI 68)

HEALTH INEQUALITIES

1. EXECUTIVE SUMMARY

1.1 An unacceptable and growing chasm exists in the UK between those with good and poor dental health. The Secretary of State for Health has recognised the disparity between the oral health of those living in poorer communities compared to those in more affluent areas.

1.2 The dental team has a vital role to play in maintaining the oral health of the nation. Its role, and that of the dentist as team leader, must not be underestimated when developing strategies to tackle oral health inequalities.

1.3 More emphasis is needed on health promotion and preventive approaches in conjunction with attempts to treat the damage caused by dental disease. It is essential that funding and remuneration systems recognise the resource needed to ensure that this preventive approach can be adopted.

1.4 The Adult Dental Health Survey (ADHS) and the Child Dental Health Survey (CDHS), are invaluable means of identifying and tracking oral health inequalities, providing information to inform the development of services that are tailored to the needs of the community.

1.5 The promotion of measures that would bring teeth into contact with fluoride would make a radical difference to the standard of oral health in the UK. These measures must be appropriate to the community.

1.6 Health promotion materials and information provided must be accessible, and gender and culturally sensitive.

1.7 Dentists are ideally positioned to offer advice to patients about a range of topics including smoking cessation, and the BDA supports smoking cessation activities including tobacco education programmes and the ban on tobacco advertising and promotion.

1.8 Activities that control alcohol consumption have the potential to have a positive impact on combating inequalities in oral health.

1.9 Dentists have been actively involved in the Healthy Schools programme and other local and national initiatives to improve nutritional status of children.

1.10 New food legislation such as the new minimum nutrition standards for schools, proposals for new labelling schemes for food, and restrictions on television advertising of high sugar have potential to have a strong impact on oral health inequalities through improving the diet of the wider population.

1.11 The BDA welcomes schemes such as Sure Start, and hopes to see an expansion in such programmes. More multi-agency collaboration is needed between the various health organisations to tackle health inequalities.

1.12 Community schemes have good potential for combating oral health inequalities. Further evaluation would be beneficial to assess long-term benefits and behaviour change.

2 INTRODUCTION AND BACKGROUND

2.1 The British Dental Association (BDA) is the professional association and trade union for dentists practising in the UK. Its 23,000-strong membership is engaged in all aspects of dentistry including general practice, salaried services, the armed forces, hospitals, academia and research, and includes students.

2.2 An unacceptable and growing chasm exists in the UK between those with good and poor dental health. There is a seven-fold difference between the populations of primary care trusts (PCTs) in England with the best dental health and those with the worst⁵⁵⁶. By the age of five, more than a third of British children have suffered tooth decay, missing teeth or fillings; in some parts of the country as many as three-quarters of children are affected⁵⁵⁷.

2.3 The Secretary of State for Health has recognised the disparity between the oral health of those living in poorer communities compared to those in more affluent areas⁵⁵⁸. Yet his commitment to elevating public health to the top of the national agenda, and his recognition that this is “pivotal” to reducing health inequalities, is being undermined by the NHS dental system he has inherited.

3. *The extent to which the NHS can contribute to reducing health inequalities, given that many of the causes of inequalities relate to other policy areas eg taxation, employment, housing, education and local government*

3.1 The dental team has a vital role to play in maintaining the oral health of the nation and their role, and that of the dentist as team leader, must not be underestimated when developing strategies to tackle oral health inequalities.

3.2 The opportunity for a dentist or member of the dental team to sit and explain to children and their parents how to care for their teeth is the most effective way of establishing good dental habits at a young age. As these children grow into adults, they may want to discuss other areas of concern with their dentist, such as their drinking and smoking habits.

3.3 The BDA supports the measures outlined in “*Choosing Better Oral Health*”⁵⁵⁹. It is essential that funding and remuneration systems recognise the resource needed to ensure that this preventive approach can be adopted. New contract reforms have introduced a target for the number of units of dental activity (UDAs) a dentist or practice must perform annually. This system of performance measurement fails to promote a more preventive approach to care because of the pressures on time it creates.

3.4 Current dental contracts mean that PCTs’ dental budgets reflect the historic level of spending on NHS dentistry in that area, and so do not always reflect the oral health needs of their local population. As a result, PCTs which have been under-funded historically continue to suffer from under-funding, causing them difficulty in commissioning services to meet patient need. This includes (but isn’t limited to) steps to address particular inequalities. Increased funding should be focused on meeting these needs of the local populations, and supplemented by PCTs having the expertise to commission appropriate services.

3.5 There is evidence that adults and children with disabilities have poorer oral health and receive less dental care than the rest of the population. The Salaried Primary Dental Care Service (SPDCS) has traditionally provided care for people with disabilities. Resources need to be provided to ensure the service continues to carry out this very important role.

3.6 SPDCS carries out work in addition to the valuable work of treating patients such as health promotion and health education. They are involved in working with Sure Start, visiting schools to promote dentistry as well as oral health, meeting with local authorities to discuss school meals and working with

⁵⁵⁶ British Association for the Study of Community Dentistry, 2003–04 survey of five-year-olds.

⁵⁵⁷ British Association for the Study of Community Dentistry, 2005–06 survey of five-year-olds.

⁵⁵⁸ “The Healthy Society”, Speech in the House of Commons, by Rt Hon Alan Johnson MP, Secretary of State for Health, 12 September 2007.

⁵⁵⁹ *Choosing better oral health: An oral health plan for England*, The Department of Health, 14 November 2005.

health visitors and school nurses. The salaried services also work with other vulnerable members of society, elderly housebound people, who are often living in near poverty situations and adults with learning disabilities or mental health problems, conditions which can also exacerbate existing inequalities.

3.7 Consultants in Dental Public Health (CsDPH) play a vital role in ensuring the commissioning of preventive services, and providing a public health input at local level. Although never published, the Dental Public Health Workforce in England status report (January 2005) identified a shortage of CsDPH. The recent reorganisation of PCTs in England has impacted upon the staffing and workload of dental public health staff and it is essential that this is not allowed to adversely impact upon public health initiatives.

3.8 The Adult Dental Health Survey (ADHS) and the Child Dental Health Survey (CDHS) are invaluable means of identifying and tracking oral health inequalities. From this information strategies can be developed to tailor services to the needs of the community. This survey underpins effective planning for improvements to nationwide oral health.

4. The effectiveness of public health services at reducing inequalities by targeting key causes such as smoking and obesity, including whether some public health interventions may lead to increases in health inequalities; and which interventions are most cost-effective

4.1 More emphasis is needed on health promotion and preventive approaches in conjunction with treatment of the damage caused by dental disease. Patients should be provided with the appropriate information in order to make informed decisions about their oral health, and information on dental services must be made available and in an accessible format to the public. To help achieve national targets, there needs to be increased appreciation of cultural differences in relation to oral care. For example, leaflets on oral health should be available in languages other than English. Cultural and gender sensitivities need to be respected.

4.2 The promotion of measures that would bring teeth into contact with fluoride would make a radical difference to the standard of oral health in the UK. Fluoride—through targeted water fluoridation, tooth brushing campaigns, fluoride rinses, or being added to milk—has a proven track record of reducing caries. Fluoridation measures must be appropriate to the needs of the community. Ideally, a reduction in sugar consumption/healthier diet should be combined with appropriate use of fluoride.

4.3 The BDA supports initiatives on smoking cessation including tobacco education programmes and the ban on tobacco advertising and promotion. Further education programmes are needed to further reduce smoking rates amongst groups with high smoking prevalence, but as part of a targeted campaign with multi-agency collaboration.

4.4 Dentists are ideally positioned to offer advice to patients about a range of topics including smoking cessation. Improving the referral rate to smoking cessation programmes is an important first step. However, it is essential that funding and remuneration systems are appropriate to ensure that this preventive approach can be adopted.

4.5 The BDA supports Smokefree and Smiling, smoking cessation guidance for primary care dental teams.⁵⁶⁰

4.6 Along with tobacco, alcohol is one of the main risk factors for oral cancer. Activities that control alcohol consumption therefore have the potential to have a positive impact on combating inequalities in oral health.

4.7 Nutrition is also an important contributing factor to oral health. There is strong evidence to link frequency of sugar consumption and dental decay. There is a high consumption of sugary sweets and drinks among children and young people in lower income groups. Children have access to sugary drinks and foods through school tuck shops, canteens and dispensing machines. Activities that limit the amount of sugary food and drink in schools are supported, and cold water machines should be available in every school. There is a strong case for encouraging local education authorities and schools to reassess their policies on these facilities.

4.8 Dentists have been actively involved in the Healthy Schools programme and other local and national initiatives to improve children's nutritional intake. In particular, many breakfast clubs have been set up and tooth brushing schemes have been built into these services in many disadvantaged areas. The BDA supports these nutritional programmes, including the Healthy Schools Programme and the School Fruit and Vegetable Scheme.

4.9 New legislation such as the minimum nutrition standards for schools, proposals for new labelling schemes for food, and restrictions on television advertising of high sugar have potential to have a strong impact on oral health inequalities through improving the diet of the wider population.

⁵⁶⁰ *Smokefree and Smiling: Helping dental patients to quit tobacco*, The Department of Health, 25 May 2007.

5. Whether specific interventions designed to tackle health inequalities, such as Sure Start and Health Action Zones, have proved effective and cost-effective

5.1 Dental health is an important part of general health and should not be considered in isolation. More multi-agency collaboration is needed to ensure joined up thinking between the various health organisations to tackle health inequalities. The BDA welcomes initiatives such as Sure Start and hopes to see an expansion in such programmes.

5.2 In many areas Sure Start has involved oral health initiatives, typically focusing on oral health promotion and fluoride toothpaste. There should be a comprehensive approach with every Sure Start Scheme having a dental care professional in the team. Dental care professionals can offer advice on all aspects of oral health including brushing teeth, use of fluoride toothpaste, advice to parents on bottle-feeding (to help reduce the incidence of bottle caries caused by sugary drinks fed to babies/young children in a bottle especially at bedtime) and advice on the advantages of offering drinks such as milk and water between meals rather than acidic or sugary alternatives.

5.3 The BDA supports schemes such as Brushing for Life, a scheme intended to promote regular brushing of children's teeth with fluoride toothpaste. The programme is delivered by health visitors who provide toothbrushes, toothpaste and dental health education material at children's eight, 18, and 36 month development checks.

5.4 Some Health Action Zones have been involved in oral health promotion. A successful example is the Plymouth HAZ that gave out packs including a toothbrush and toothpaste to every child at their six–nine month check-up. Community schemes such as these have the potential to combat oral health inequalities. Further evaluation would be beneficial to assess long-term benefits and behaviour change.

January 2008

Memorandum by the Association of Directors of Public Health (HI 69)

HEALTH INEQUALITIES

The Association of Directors of Public Health (ADPH) has been in existence for over 150 years. The aim of the ADPH is to support all Directors of Public Health (DsPH) across the UK in improving and protecting the health of the population by working to:

- collate and present the views of DsPH on public health policy to national governments, the media and other organisations;
- influence legislation and policy at a local, regional, national and international level;
- facilitate a support network for DsPH to share ideas and good practice and support problem-solving;
- identify and fulfil the development needs of DsPH where practicable and appropriate;
- in collaboration with others, further the development of comprehensive, equitable public health policies through relevant statutory and other bodies.

THE CONTRIBUTION OF THE NHS TO REDUCING HEALTH INEQUALITIES

Executive Summary

The ADPH very much welcomes this inquiry. The dogged persistence of health inequalities is one of the greatest challenges facing government and the NHS today.

The difficulty in addressing health inequalities is because provision of services often results in disproportionate take-up from the relatively less deprived thus increasing inequalities. The obvious answer is to target services to those most in need but this can be politically unpopular. In addition targeting must be very well defined using population segmenting techniques such as social marketing if it is to be successful in closing the gap.

There are some services (eg smoking cessation) that are cost-effective and when targeted appropriately are showing progress against inequalities but stronger evaluation and extension of successful programmes should be more strongly supported.

GP services and practice-based commissioning need to be incentivised to address health inequalities and include preventive measures as a matter of course.

Many national and local policies (including from the NHS and Department of Health) are not “proofed” for health inequalities before implementation and some have inadvertently caused an increase in health inequalities.

Throughout our response the ADPH has considered health inequalities as a population issue ie inequity defined by health need. This is not the same as the “post-code lottery” which is unequal access to services based on geography. Addressing the former will improve the health of the population whereas addressing the latter helps individuals.

DETAILED RESPONSE

1. The extent to which the NHS can contribute to reducing health inequalities, given that many of the causes of inequalities relate to other policy areas eg taxation, employment, housing, education and local government.

1.1. ADPH recognises that the NHS is neither the sole nor major agent in reducing health inequalities. The prime drivers of health inequalities in the UK are income, social and educational inequalities. However, the NHS can contribute to a reduction in health inequalities in a number of ways.

1.1.1. The systematic application of equity audits to ensure that health service provision and use is equitably distributed across the population.

1.1.2. The development, funding and scale up of targeted interventions which specifically support the health and well-being of disadvantaged communities and individuals with a specific focus on delivery of universal high quality primary care eg CVD prevention, care and treatment.

1.1.3. Participation in local and national schemes which aim to improve inequality in income or educational attainment (examples include Warm Front initiative, local efforts to improve benefit uptake, Healthy Schools Standard).

1.1.4. Taking its responsibility as a major employer seriously by ensuring it has the right incentives in place to address inequalities and encourage healthy living for its staff.

1.1.5. Health inequality impact assessments should be usual practice on all NHS policies before implementation.

2. The distribution and quality of GP services and their influence on health inequalities, including how the Quality and Outcomes Framework and Practice-based Commissioning might be used to improve the quality and distribution of GP services to reduce health inequalities.

2.1. The distribution of GP services is relatively fixed but the NHS has an opportunity to direct marginal resource to areas of greatest health need. Using measures such as under-doctored areas, although not definitive (since delivery of primary care is by multi-disciplinary teams), can provide a guide. It is important to have the highest quality primary care in the areas with the greatest health need, which tends not to be the case at present. More targeted use of Public Health / School nurses to address eg sexual health, teenage pregnancy, obesity issues etc would also support addressing inequalities.

2.2. One major inequality issue in Primary Care is that some of the most disadvantaged people may not even be registered with a GP or may change practices often and fall outside the system.

2.3. The quality and outcome framework (QOF) has been a relatively weak tool in terms of improving quality in primary care but could have greater impact with more public health incentives, particularly those where the reduction of inequalities is a clear target. Disease registers and brief interventions for lifestyle change re smoking, alcohol and obesity, screening and immunisation programmes should be included. Even where incentives exist eg re CVD prevention there are still major inequalities between practices.

2.4. Practice-based commissioning would have greater impact if it placed more emphasis on encouraging practices to improve the quality of the primary care they deliver rather than achieving marginal improvements in the delivery of secondary care. More emphasis on complete pathways including preventative measures would support work against health inequalities.

2.5. Practice-based commissioning should be required to show they are working towards addressing population needs (including addressing inequalities) as well as improving quality and making better use of resources.

3. The effectiveness of public health services at reducing inequalities by targeting key causes such as smoking and obesity, including whether some public health interventions may lead to increases in health inequalities; and which interventions are most cost-effective.

3.1. There is good evidence that some successful preventive interventions (eg smoking cessation) are cost-effective and have the potential to reduce health inequalities. However, these do not yet have sufficient reach. A priority should be to ensure these services are scaled up and targeted appropriately. In other areas (eg obesity) services are not yet being delivered in a way which is sufficiently evidence-based and comprehensive in delivery to make a significant impact on broad health outcomes.

3.2. It is likely that public health interventions which are inequitably delivered may be contributing to a widening of health inequalities (examples include some smoking cessation services, screening programmes, alcohol treatment services). This is most often due to the tendency of the least deprived to garner resources and to gain the greatest benefit from services.

3.3. Even targeted services, particularly when area-based can widen health inequalities because of this tendency. The ability (and not just the opportunity) for the most disadvantaged to access services is critical and more needs to be done to understand approaches to increase this. The use of social marketing techniques has the ability to support this (examples include the smoking cessation work in Knowsley, Derbyshire and Nottingham).

3.4. Targeting services costs more and there are disincentives in number-based national targets (eg counting the number of smoking quitters rather than who they are).

3.5. Some very disadvantaged groups (eg migrant workers, travellers, prisoners etc) are not considered in policy-making and require highly targeted services.

3.6. Initiatives relying heavily on health promotion approaches without full consideration of market segmentation (eg social marketing methodology) are often cited as increasing inequalities because information is more accessible and acted upon more readily by the more affluent and better educated.

4. Whether specific interventions designed to tackle health inequalities, such as Sure Start and Health Action Zones, have proved effective and cost-effective.

4.1. Specific community-based interventions such as those cited have been demonstrated to lead to significant health benefits for those who access the services. As with Sure Start they need to be evidence-based and locally driven. However, as mentioned above, any area-based initiatives will tend to benefit those who are relatively less in need (see for instance the national evaluation of Sure Start).

4.2. It is increasingly clear that further attention will need to be given to targeting the resources available through and improving access to such programmes so that the most economically deprived individuals and groups can benefit from the programmes.

4.3. In part the difficulty in providing evidence of benefits relates to the time-scales needed for such programmes to demonstrate tangible results. The balance between being seen to achieve quick wins and gaining longer-term benefits often leans to the former whilst tackling health inequalities requires an emphasis on the latter.

5. The success of NHS organisations at co-ordinating activities with other organisations, for example local authorities, education and housing providers, to tackle inequalities; and what incentives can be provided to ensure these organisations improve care.

5.1. There are myriad examples of the NHS contributing to inter-sectoral and inter-organisational initiatives aimed at reducing health inequalities. However, initiatives are generally poorly evaluated, sustainability is often overlooked, and opportunities to identify with and scale up successful initiatives are not grasped.

5.2. The moves towards increasing co-terminosity and joint Director of Public health appointments is supporting joint working and the DPH is well-placed to lead on health inequalities. There are many examples where this is working very well. However, this relies on a well-resourced team working across sectors. Local Area Agreements are major drivers with joint commissioning the main tool. At District level, the good work achieved before recent PCT restructuring must not be lost despite fewer DPH posts.

6. The effectiveness of the Department of Health in co-ordinating policy with other government departments, in order to meet its Public Service Agreement targets for reducing inequalities.

6.1. Inequalities are a multi-faceted problem and require a multi-pronged attack from different organisations working in partnership. The collaboration between agencies often works well locally but would be further enhanced by stronger national co-ordination between government departments to ensure national drivers and incentives for different organisations provide synergy at a local level.

6.2. The ADPH believes that the lead for cross-sectoral work on inequality should often come not from the Department for Health but from the Treasury since the greatest drivers for and barriers to the reduction in inequalities are economic. This would also support the robust financial and strategic planning required to realise the benefits of the Wanless report recommendations.

6.3. There are examples of notable success in cross government working. These include the recent progress on smoking legislation, seatbelt legislation, etc. ADPH believes that future government policy should be informed by these successes and that fears of public abreaction against government intervention in public health policy are largely unfounded and can be effectively managed. Possible areas for future cross government action which would have significant impact on health status and reduce health inequalities include: pricing and availability of alcohol and food labelling.

6.4. Tobacco is still the main contributor to the gap in life expectancy between rich and poor. The recent proposals re graphic warnings on cigarette packets and sale of tobacco from vending machines are welcomed. Additional legislative protection should be considered to provide proper protection for children from secondhand smoke. The ready availability of cheap smuggled and counterfeit tobacco in the most deprived communities makes quitting smoking more difficult. Cross government action is needed to tackle this effectively.

7. Whether the Government is likely to meet its Public Service Agreement targets in respect of health inequalities.

7.1. Targets will not be reached unless there is both local work and national incentives to drive progress. Government should be willing to acknowledge and accept its stewardship role in protecting and improving the public health even when this conflicts with powerful vested interests.

7.2. Current trends indicate that the infant mortality and life expectancy targets will not be met. The PSA targets are achievable but cannot be delivered through NHS-led health interventions alone. Continued efforts to reduce child poverty and improve educational attainment and a redirection of public policy towards reduction of income inequalities will be required for long-term progress against health inequality targets.

7.3. Continual re-structuring combined with the raiding of "Choosing Health" monies to fund NHS deficits has had a detrimental effect on public health programmes and delayed the achievement of targets in some areas. Public Health goals, particularly such intransigent ones as inequalities require a long time-line and consistent work. The government should take this into account before considering further changes in NHS structures.

January 2008

Memorandum by Slimming World (HI 70)

HEALTH INEQUALITIES

SLIMMING WORLD—AN INTRODUCTION

Founded in 1969, Slimming World is the most advanced and effective weight management organisation in the UK. Each year Slimming World influences over 3 million people to eat more healthily and adopt a healthier, more active lifestyle each year. Slimming World holds 5,500 weekly groups across the UK run by a network of 2,500 Slimming World trained consultants. Over 5 million people have attended Slimming World group meetings, with individual weight losses achieved from 1 stone to over 25 stones.

Slimming World Consultants are all recruited from successful group members, working in their local community. Because groups are held in the heart of communities, eg church halls, sports clubs and other local venues, we are uniquely placed to reach a range of people from very diverse social and ethnic backgrounds.

Every week Slimming World helps around 250,000 people who fund their own attendance, to manage their weight. Each month 50,000 new members join and 9,500 men attend our groups. A further 50,000 people chose alternative channels to access Slimming World support through the internet, Slimming World's magazine and at home service.

In 2000, Slimming World pioneered a subsidised Slimming World on Referral programme, which allows health practitioners to offer patients free membership to one of our weekly groups in their area. The programme is proving very popular with over 30 primary or secondary care teams now offering the service to their patients. We have also set up Slimming World on Referral schemes with Sure Start groups.

We are also working with a number of the spearhead PCTs who are developing obesity strategies and services. Slimming World operates a total of 1540 groups, run by 740 Slimming World trained Consultants in the 62 spearhead PCT areas. Over 72,000 members attend Slimming World groups each week within the spearhead PCT areas and 16,000 join each month. We have the capacity to double the membership in these areas with the current Slimming World infrastructure and our long term aim is to develop the number of groups to 3,300 with over 165,000 members attending each week (that is to support 2% of the overweight and obese population in these areas).

Slimming World welcomes the opportunity to comment on this inquiry and we hope you will find our comments of assistance.

EXECUTIVE SUMMARY

1. Slimming World believes that the way forward in tackling obesity is a whole society approach and that partnership with private sector organisations such as Slimming World can play a constructive and effective role to support health services tackle health inequalities.
2. The role of private sector could be further enhanced by effective take up of Practice Based Commissioning (PBC). As a result, we believe the Department of Health should develop clearer signposting to services that meet set service standards or criteria. This would encourage the Commissioners and PCTs to implement PBC more effectively and explore more innovative options to tackle health inequalities.
3. We also suggest that in addition to allocating points for measuring patients' BMI, GPs should be allocated points for referring obese patients to services that can help and support them to take active steps to address their weight issues. For example GPs could be allocated points for referring patients to weight management services or exercise schemes in their local area.

HEALTH INEQUALITIES

We would in particular like to comment on the following aspects of the inquiry:

The distribution and quality of GP services and their influence on health inequalities, including how the Quality and Outcomes Framework and Practice Based Commissioning might be used to improve the quality and distribution of GP services to reduce health inequalities;

1. Slimming World believes both the Quality and Outcomes Framework (QOF) and Practice Based Commissioning (PBC) have considerable potential to improve the quality and distribution of GP services to reduce health inequalities.
2. As acknowledged by the Foresight report, there is a greater prevalence of obesity among poorer social groups⁵⁶¹.
3. Therefore, it is important that in order to tackle health inequalities, there must be systems in place that encourage health professionals to deal more effectively with health issues, such as obesity, that are more prominent in these target groups.
4. Under the QOF indicator on obesity, GPs can accumulate 6 QOF points by producing a register of patients aged 16 and over with a BMI greater than or equal to 30 in the previous 15 months.
5. Slimming World believes that in addition to allocating points for measuring patients' BMI, GPs should be allocated additional points for referring obese patients to services that can help and support them to take active steps to address their weight issues. For example GPs could be allocated points for referring patients to weight management services or exercise schemes in their local area.
6. Our Slimming World on Referral programme provides an excellent example of how PBC can be effectively used to reduce health inequalities.
7. In 2000, Slimming World pioneered a subsidised Slimming World on Referral programme in collaboration with Greater and Central Derby PCTs, which allows health practitioners to offer patients free membership to one of Slimming World's weekly weight management support groups.
8. Our initial research study investigated the feasibility, practicalities and cost-effectiveness of referring patients from primary care into Slimming World groups⁵⁶². The study demonstrated that beneficial weight loss could be achieved in a significant percentage of patients referred to Slimming World within a population that includes a high percentage of socially disadvantaged groups and low socioeconomic status. We also discovered that people who had never considered joining a weight management group, perhaps because of the financial commitment, did so when encouraged and subsidised by their GP. As well as helping patients lose weight, significant improvements in mental well-being were also reported after 12 weeks. Furthermore, over 70% of those completing the free 12-week programme went on to self-fund further attendance at the group, many reporting that now they had seen improvements in their weight and health they were willing to invest their own time and money to continue to improve their lifestyle.
9. Since the nationwide launch of the programme in 2002, we are now working in partnership with over 30 primary or secondary care teams to offer the Slimming World on Referral scheme to patients.
10. Data from the first 2,100 patients to finish 12-week programme are very encouraging:
 - 34% were considered morbidly obese (BMI > 40)
 - Average attendance was 9.4 weeks (of 12)
 - 64% completed the programme (10 of 12 weeks)

⁵⁶¹ Foresight Tackling Obesity: Future Choices Project, 17 October 2007, p.127.

⁵⁶² Feasibility and benefits of implementing a Slimming on Referral service in primary care using a commercial weight management partner. Public Health (2006) 120, 872–881.

- Average weight loss of completers was 5.5% (4.2% across total population)
- 55% of completers lost \geq 5% bodyweight (39% of total population)
- Non-completers attended an average of 5.6 weeks and lost 2.1% of bodyweight

11. Based on the evidence of success in these schemes increasing numbers of PCTs are rolling the Slimming World on Referral programme out to GP practices within their Trust.

12. However, considering that on current trends, by 2050, 60 per cent of men, 50 per cent of women and 25 per cent of children and young people will be obese⁵⁶³, take-up of PBC for weight management services by GPs could be dramatically improved.

13. In our experience PCTs and GPs are not always aware what types of services they can commission. This creates entry barriers to new service providers and can prevent the introduction of innovative interventions, especially interventions designed to support healthy lifestyles etc, which often can reduce the use of more expensive interventions in the long run.

14. Therefore, we feel that to overcome this problem, the Department of Health should develop clearer signposting to services that meet set service standards or criteria. This would encourage the Commissioners and PCTs to explore more innovative options and improve the effective implementation of commissioning across the country in order to address health inequalities and tackle long-term conditions such as obesity.

The effectiveness of public health services at reducing inequalities by targeting key causes such as smoking and obesity, including whether some public health interventions may lead to increases in health inequalities, and which interventions are most cost-effective;

1. The effectiveness of public health services at reducing inequalities by targeting obesity is variable across the UK. However, Slimming World has a consistent and effective range of services available nationally. We are uniquely placed to provide support in tackling obesity across a range of platforms. We can help the individual, the family, a GP or practice nurse wanting to refer their patient, and businesses wanting to set up occupational health schemes. With almost two thirds of the adult population now overweight or obese, the challenge it poses to the NHS is enormous, not least in financial terms. The government cannot tackle this alone and private sector organisations can play an important role in supporting the health services to meet their health improvement targets and to reach more people than they alone can, and thus tackle health inequalities.

2. Our subsidised Slimming World on Referral programme, as described above, is being used by PCTs to address health inequalities and was piloted in a population that included a high percentage of socially disadvantaged groups and low socioeconomic status. Offering free membership and attendance ensures equality of access to Slimming World.

3. Importantly, the service was shown to be more cost-effective than other current weight management options such as setting up in-house services or prescribing of anti-obesity medication. For example, the cost of the 12-week Slimming World on Referral programme is £44.50 per patient which is on average a third of the cost of drug treatment such as sibutramine and orlistat (which also does not include the cost of providing a concomitant weight management programme as recommended by NICE). Furthermore, in addition to the short-term cost-effectiveness whilst patients are participating in the scheme it is also important to consider the long-term benefits of such a scheme, which provides support in behaviour change to help patients adopt healthier lifestyle habits.

4. The Foresight report estimated that by 2050 there will be additional costs to the NHS of between £5.5 billion and £6.5 billion because of obesity⁵⁶⁴. Any decrease in obesity will also have huge cost benefits to the NHS as well as helping individuals live longer, healthier lives.

5. One of the long-term benefits of behaviour change programmes is that their reach extends much further than the member attending a group. Many members use the advice they receive at their Slimming World group to help other family members at home. Our research shows that three quarters of members are influencing their family to eat more fresh fruit and vegetables, less sugary and fatty food and fewer convenience foods, with over a third inspiring family members to be more active in everyday life⁵⁶⁵.

6. In January 2006 we also launched a new initiative called Family Affair, designed to give even more targeted support to families, and help tackle the rising prevalence of adolescent obesity. The Family Affair scheme directly helps 11 to 15 year olds to manage their weight if their parent(s) and family GP believe it is right for them to do so, and with guidance on weight change directed by the adolescent's health care team. The scheme engages the whole family in making changes to adopt new healthier eating habits and a more active lifestyle. By focusing on behaviour change rather than weight loss we empower adolescents to take responsibility for developing their own personal route to healthy eating and activity. No fees are charged

⁵⁶³ *Official Report*, House of Commons, 17 October 2007, Volume 464, Column 825.

⁵⁶⁴ Foresight Tackling Obesity: Future Choices Project, 17 October 2007, p.40.

⁵⁶⁵ Influence of Slimming World's lifestyle programme on diet, activity behaviour and health of participants and their families. Submitted to *Journal of human Nutrition & Dietetics* (2007).

for adolescents between 11 and 16 wishing to attend our groups along with their family and with their health carer's agreement. To date nearly 17,000 11 to 15 year olds have benefited from our support through this scheme.

7. Another example of how private sector organisations can effectively support health services in tackling health inequalities would be Slimming World's workplace referral scheme. In the past couple of years, Slimming World has been successfully working with a number of employers who wish to offer their employees opportunities to improve their lifestyle. Recent and current examples include Land Rover and Jaguar, which both offer financial support to employees wishing to participate in Slimming World groups in their local area. We also run groups that are based in the work place itself and funded by the employer.

8. We believe the Government could encourage employers to take a more active role in encouraging their employees to achieve healthier lifestyle. Apart from the obvious benefits for the employer in terms of having healthier and more productive work force, there is also huge potential to reach many more people who would not necessarily come to the National Health Service to seek advice and support, and therefore play an important role in tackling health inequalities.

CONCLUSION

In summary our recommendations are:

1. In addition to allocating points for measuring patients' BMI, GPs should be allocated additional points for referring obese patients to services that can help and support them to take active steps to address their weight issues. For example GPs could be allocated points for referring patients to weight management services or exercise schemes in their local area.
2. In order to improve the effective implementation and take up of commissioning across the country, the Department of Health should develop clearer signposting to services that meet set service standards or criteria. This would encourage the Commissioners and PCTs to explore more innovative options to address health inequalities and to find long-term solutions to conditions such as obesity.
3. Private sector organisations, such as Slimming World, can play an important role in supporting the health services to meet their health improvement targets and to reach more people than they alone can, and thus tackle health inequalities.

January 2008

Memorandum by Arthritis Care (HI 71)

THE CONTRIBUTION OF THE NHS TO REDUCING HEALTH INEQUALITIES

1. EXECUTIVE SUMMARY

1.1 Nine million people in the UK are affected by arthritis, including 8.5 million with osteoarthritis, 400,000 with rheumatoid arthritis, and approximately 12,000 children with juvenile idiopathic arthritis. An effective NHS is vital to ongoing management and treatment of these conditions. The health of a person with arthritis requires effective self-management, monitoring of the progression of their condition, and close monitoring of drugs which often have harmful side-effects. Many people with arthritis rely on good and early diagnosis, access to life-changing drugs, access to a number of support services such as physiotherapy and counselling, and reactive medical care such as surgery.

1.2 Poor treatment exacerbates existing equality issues. For example, poor services for people with arthritis that do not reflect their needs could lead to long-term disability and often to mental health comorbidities, forcing them to leave work, rely on low-income benefits, and worsening their bio-psychosocial health. Since it is shown that people with disabilities are twice as likely to live in poverty⁵⁶⁶, any factors that contribute to disability must be strictly avoided

1.3 GPs represent a very important element in the diagnosis and treatment of arthritis, indeed 1 in 4 GP visits are related to musculoskeletal conditions. Arthritis and musculoskeletal conditions do not, however, appear in the Quality and Outcomes Framework (QOF), which was introduced in part to prevent inequalities in care. By only providing incentives to monitor and diagnose certain conditions, we are concerned that many people with arthritis may not be receiving vital early stage care and long-term monitoring. This undermines effective musculoskeletal service provision and needs to be addressed, either by inclusion in the QOF or by reassessing incentive mechanisms for primary care.

⁵⁶⁶ Guy Parckar, *Disability Poverty in the UK*, Leonard Cheshire Disability, Jan 2008.

1.4 The NHS is a central plank in the management of arthritis and any potential for inequality must be avoided. Failing to produce a consistent service could have a profound effect on the millions of people with arthritis in the UK. Arthritis Care believes inequalities are occurring where established guidance on care pathways and treatments are not being uniformly adhered to. For example:

- Where some Primary Care Trusts (PCTs) do not facilitate the prescription of treatments such as TNF α inhibitors, in line with NICE guidelines, people with the most severe forms of arthritis are at risk of severe disability and premature mortality.
- Where effective and established service frameworks are not adhered to, the chances of positive health outcomes are significantly diminished. On this basis, we will talk about the Musculoskeletal Services Framework later in this document.

1.5 There is an overall lack of priority for those policies to which no target is tied. There should be mechanisms in place to ensure that evidence-based frameworks are followed, to ensure delivery of NICE guidance, and to maintain a primary care system that treats conditions equally and has appropriate resourcing. Without direction on such issues, there can be little assurance that an effective health service is being delivered universally.

1.6 As part of its responsibilities of providing information and support, it is essential that the role of the NHS in public health work is strengthened. This must include producing or sign-posting to good quality information, promoting healthy lifestyles, and highlighting typical health risks. Joined up work on disseminating information and providing support services is very important not only to long-term conditions, but also to public health in general. Arthritis does not feature prominently in public health messages and the provision of self-management support is limited. Seeing as good information of this nature is vital to effective outcomes for people with arthritis, limited and uneven provision of information will inevitably contribute to health inequalities.

1.7 Service users should be consulted during the commissioning process of local health services, however this is still extremely rare. The lack of effective consultation will impact on areas that are unable to organise effectively and create uneven services in terms of quality and overall effectiveness to meet the needs of service users. It is vital to enable local communities to engage in reducing health inequalities, with a particular effort to include people with disabilities and long-term conditions as service users in this process.

2. INTRODUCTION

2.1 Established in 1947, Arthritis Care is the UK's leading user-led organisation benefiting people with arthritis. Our mission is to offer the nine million people with arthritis in the UK the information and support they need to make informed choices about managing their arthritis, to reach their potential in society and participate in their communities.

2.2 Factors such as established treatment mechanisms, access to good information and support services, access to vital drug therapies, and self-management are central to a good quality of life for people with arthritis. People who are able to expect these elements in their care can also expect to have better health outcomes and be able to manage their condition more effectively.

2.3 A lack of universality in what people with arthritis can expect from healthcare services represents a significant health inequality. This occurs as a result of the absence of a joined-up approach to healthcare; incentive mechanisms such as the QOF; and weak implementation of clinical guidelines and Department of Health policies.

2.4 Based on the following information and considering the recommendations at the end of this paper, we suggest that such inequalities in the effectiveness of services currently exist and can be improved.

3. FACTUAL INFORMATION

3.1 *The Quality and Outcomes Framework*

3.1.1 Long-term risks to people with arthritis are exacerbated by the lack of effective early intervention and long-term monitoring include loss of mobility, joint-replacement surgery, and a greater overall impact on health and well-being. This leaves people more at risk of having to leave work and claim state benefits, contributing to non-health related inequalities such as those relating to employment opportunities and the welfare trap. These factors further impact on physical and mental well-being.

3.1.2 Despite the prevalence rate of arthritis and the fact that 1 in 4 GP visits relate to a musculoskeletal condition, arthritis does not feature in the Quality and Outcomes Framework (QOF). By incentivising a focus on some conditions, people with other conditions that are omitted, such as arthritis, are missing out on key, valuable interventions.

3.1.3 The Arthritis and Musculoskeletal Alliance (ARMA)⁵⁶⁷ published a study in 2006 which revealed that two thirds of the rheumatologists surveyed believed that the omission of arthritis from the QOF had either made service provision for people with arthritis worse or not changed it at all. Health inequalities arise through the negative impact of the QOF and are widened as services for other conditions that are in the QOF improve. People with arthritis are being left behind.

⁵⁶⁷ ARMA is the UK umbrella organisation of arthritis service user groups, health professionals and researchers.

3.1.4 There is a further impact on people's long term monitoring. People with asthma and diabetes, two conditions that feature in the QOF, are invited annually for a flu jab along with a review of their treatment. In comparison, people with arthritis are not routinely invited to important health checks. They are more likely to visit their GP only if they are pro-actively seeking particular assistance or support. It is known that vulnerable groups or those with the highest risk of experiencing inequalities are less likely to access services pro-actively and without the impetus that QOF measures represent, those health inequalities are unlikely to improve.

3.1.5 The QOF is having a further negative impact on an information prescription pilot Arthritis Care is currently involved in⁵⁶⁸. The scheme allows health professionals to prescribe information about a long-term condition as they would normally prescribe medicine. The numbers of people with arthritis being issued an information prescription in comparison with people with asthma and diabetes, which feature in the QOF, is very low. Without being in the QOF, GP's incentive to participate in such schemes is diminished, even though this represents an excellent opportunity to provide information to the people that really need it.

3.2 *Information services, including public health*

3.2.1 When a person is diagnosed with arthritis, it is extremely important that they receive up to date information on how they can manage their condition. Supporting people with arthritis to self-manage is a key component in preventing health inequalities. Knowing how to manage their arthritis and understanding what it means to their life is important for empowering individuals and also equips them to maximise their own health outcomes.

3.2.2 Organisations such as Arthritis Care offer a range of self-management training courses, as well as information and support from a variety of resources such as helplines, peer support groups, an online discussion forum, and information booklets. Appropriate sign-posting at the point of diagnosis will help people with arthritis to access such services and help to generate a wider knowledge base from which individuals can help to manage their condition effectively and perhaps assist others. Enabling people to take these steps is useful in narrowing health inequalities and reduces the burden of care on the NHS. It can also help them to be more empowered in other aspects of their life, impacting on some of the causes of health inequalities such as unemployment.

3.2.3 Arthritis Care recently conducted a survey of over 1,500 people with arthritis and they called for a greater awareness of arthritis amongst the general public and health professionals. A general lack of awareness can often lead to health inequalities as people can find it difficult to ask for or achieve adjustments, such as changes to the workplace to help a person with arthritis to stay in work. Similarly, differing levels of knowledge amongst health professionals will create disparities in both the diagnosis and treatment of arthritis. The NHS has a responsibility to create training mechanisms which best serve people with arthritis and must communicate to the general public the risk factors of certain forms of arthritis and the realities of living with the condition.

3.2.4 In widening the information prescription scheme detailed above, it is important that the NHS does not exacerbate inequality by making materials inaccessible or that do not cater for people that most need them, such as using online information for people that may not have private access to the internet.

3.3 *Implementation of the Department of Health's Musculoskeletal Services Framework*

3.3.1 An effective framework setting out principles for care is extremely important in reducing inequalities in the health service. If a person presents with symptoms of a musculoskeletal condition to their GP or other health professional, slow or incorrect diagnosis and referral could have a significant effect on the long-term outcome, treatment, and management of their condition. The Musculoskeletal Services Framework (MSF) sets out protocols that make visits to primary care locations more effective and creates links with secondary care services and self-management support, enabling services users to take a greater control of their condition. Inconsistent application of these protocols cultivates inequalities as the major benefits of the MSF will extend only to those in a PCT that decides to adopt it, not, as should be expected, to every single service user.

3.3.2 The MSF, published in 2006 by the Department of Health, was produced in collaboration with Arthritis Care, ARMA, and the wider musculoskeletal community. The framework was based on service-user feedback and specialist advice and forms the basis of an effective patient pathway through primary and secondary care which meets the needs of people with arthritis and other musculoskeletal conditions.

The MSF represents a large piece of work on the part of the musculoskeletal community and the Department of Health, with massive potential to reduce health inequalities. Despite this awareness remains low, indeed, discussions with commissioners in an one Strategic Health Authority (SHA) revealed they were not even aware of its existence.

⁵⁶⁸ This is a Department of Health pilot scheme in which Arthritis Care has collaborated with Asthma UK, Diabetes UK, and Hammersmith and Fulham PCT.

3.3.3 Please see the following parliamentary question from 25 July 2007:

Greg Hands (Con): To ask the Secretary of State for Health what steps have been taken to implement the Musculoskeletal Services Framework; and if he will make a statement. [151486]

Ann Keen (DoH): The Musculoskeletal Services Framework was published as good practice guidance, and as such the Department is not mandating its implementation. However, adopting this good practice will help organisations towards achieving the 18 weeks target.

The outcomes of poor services can be avoidable disability, living in chronic pain, a greater potential for costly major surgery in the long term as well as increased mortality. By prescribing the MSF as best-practice rather than enforcing it as with other service frameworks, the Department of Health risks developing service inequalities. Consequently, the systems laid down in the MSF will not enjoy the successes of other protocols such as the national service framework for coronary heart disease which has enabled considerable progress in improving heart disease services since its publication in 2000. This can be avoided by a clear directive on implementing the MSF.

3.3.4 While it is very important that the MSF is cited as a useful tool to meeting 18 weeks targets, it is equally important that the framework has a longer-term role in ensuring the consistent provision of services to people with a range of conditions that could be present for the rest of person's life, especially since many can occur at any age.

3.4 Access to anti-TNF treatment

3.4.1 PCTs are legally obliged to provide funding to meet the recommendations of NICE guidance within three months of it being published. We know that these are not met consistently. (The NICE appraisal process has been discussed in a previous inquiry and we will not go into detail about that process in this paper, though there are over-arching issues that we hope that these inquiries will uncover).

3.4.2 NICE has established guidance for treating severe rheumatoid arthritis (RA) by using TNF α inhibitors. In a survey in 2006, ARMA discovered that 20% of rheumatology units were unable to prescribe TNF α inhibitors to every person with RA identified as eligible in accordance with guidance. The most common reason for this was that PCTs had overspent and would not release the funding.

3.4.3 Furthermore, 15% of units stated that a cap had been imposed on the number of people with RA to whom they could prescribe TNF α inhibitors. In some cases, this meant that only 10 people with RA had the available funding for treatment compared with up to 500 people in units that did not have a cap.

3.4.4 This is an example of the NHS contributing to health inequalities. An effective means of enforcing the availability of funding to PCTs to enable them to follow NICE guidance would have the effect of challenging these inequalities.

3.5 Commissioning

3.5.1 Allowing service users and interest groups to input into the commissioning process enables healthcare providers to offer more targeted services that meet the needs of service users, particularly those with long-term conditions. Without such a consultation process, the quality and effectiveness of services risks being uneven, and risks not being representative of the needs of service users merely from the lack of opportunity to influence the process. While recognising the need for flexibility in delivery, basic standards in this process need to be adhered to. Such standards are currently very patchy.

3.5.2 Creating expert service users is a further positive step towards reducing health inequalities. Advising service users on how to effectively interact with local health authorities enables monitoring of service provision and involves service users in the decision making process.

3.5.3 Arthritis Care runs a training course which gives service users the skills and knowledge they need to influence local health decision-makers. This has enabled them to contribute effectively to service development and has proved fruitful for service users, deliverers, and planners alike. This is a useful model for service user involvement in commissioning.

3.5.4 The benefits of this user-involvement can be seen in the following example: an ARMA local network⁵⁶⁹ became actively engaged with the commissioning process in the Morecambe Bay area, which spans North Lancashire PCT and Cumbria PCT, when proposals were announced by local NHS organisations regarding the establishment of Clinical Assessment and Treatment Services (CATS). These plans, which outsourced services to the independent sector, had been developed in isolation from public consultation and as a consequence they did not reflect the needs of local service users. The network worked in partnership with NHS employees and local groups to ask for a full public consultation on these proposals.

Once the local NHS organisations agreed to hold a consultation, the ARMA local network wrote letters to decision-makers to determine how the changes would affect service users and met with PCTs, managers and officials about the proposals. The network members also attended public meetings and encouraged residents to respond to the consultation, as well as submitting their own response. Following the

⁵⁶⁹ ARMA local networks are made up of individuals and groups representing ARMA locally.

consultation, the CATS proposals have changed significantly, and the ARMA local network ensured that the voice of service users and other key stakeholders was heard clearly in the deliberations. The service user lead continues to have a direct dialogue with the commissioning organisations as the project develops.

3.5.5 In this instance, obtaining the view of services users was not routinely done. Had the local network not become involved, the service would not have represented the needs of service users to the extent it was eventually able to. This absence of direct and thorough consultation could have a direct impact on health inequalities, especially in those areas that are not able to organise effectively. This could have a particular impact on people with arthritis and other long-term conditions as poor services can lead to early disability, being unable to work and relying on alternative state benefits, therefore compounding wider inequality issues.

4. RECOMMENDATIONS

4.1 A comprehensive review of the QOF should be undertaken to assess its impact on services. This should include an examination of how primary care incentive schemes impact on the level of care and priority given to all service users, including people with arthritis.

4.2 Effective information services and sign-posting to best utilise available resources and help people with arthritis to self-manage. Improved resourcing of voluntary organisations such as Arthritis Care to deliver these services would help in achieving public health aims by utilising existing high quality services.

4.3 Top level commitment to the implementation of the Musculoskeletal Services Framework at all levels to ensure that the quality and effectiveness of services are of the right standard throughout the country.

4.4 Enforcing and monitoring implementation of NICE guidance so that all patients have access to essential treatments.

4.5 National and local leadership is required to link health policy and service delivery with that delivered by other government departments, especially the Department for Work and Pensions. There also needs to be greater collaboration between the health service and social care providers, the voluntary sector, and employers to improve the opportunities of people with arthritis and other long-term conditions.

4.6 Meaningful involvement and support for service users in all stages of commissioning to place them as a central component in decision-making and to better monitor the potential for health inequalities.

January 2008

Memorandum by the Terrence Higgins Trust (HI 72)

HEALTH INEQUALITIES

1. Terrence Higgins Trust (THT) is the UK's largest non-statutory provider of HIV and sexual health services. THT provides diagnostic, care and prevention services for HIV and STIs and works to reduce the stigma and discrimination encountered by people with HIV and poor sexual health.

2. Inequality impacts upon people with HIV and poor sexual health in a number of ways, both legal and societal. It both contributes to poor sexual health and is, in turn, exacerbated by that poor sexual health, creating a cycle of inequality. In many areas, the NHS can make a positive contribution; in some, unfortunately, it is also capable of making a negative one.

3. This submission highlights three areas of health inequality where THT believes a small change could have a large impact upon both public and individual health and on reducing existing health inequalities. It also addresses the cost-effectiveness of targeted HIV prevention work as a public health intervention.

DISCRIMINATION

4. Many people with HIV encounter discrimination as a result of their condition. In a survey of 1385 people with HIV in London (Elford et.al. 2007), almost a third had encountered direct discrimination. Within this group, half had been discriminated against in a healthcare setting and the most common situations cited were dentists and GP settings. THT regularly speaks with people who have been refused dental services, put to the end of minor surgery waiting lists or otherwise treated inequitably, often explicitly because of their HIV status. We would be happy to provide the Select Committee with case studies giving examples of this.

5. Many people with HIV are reluctant to inform their GP of their HIV status and, in general, most people who test for HIV prefer not to do so at their GP surgery, despite Government policy and CMO advice urging GPs to increase their offers of HIV testing. Similarly, many people are reluctant to approach their GP if they suspect or fear that they have a sexually transmitted infection. While in part this is due to

misinformation, it is also true that levels of understanding of sexual health issues are generally low in GP practices and this can lead to stigma and, in some cases, discriminatory behaviour from GPs and other practice staff.

6. THT believes that appropriate training for GPs and other primary care staff such as dentists would reduce the discrimination currently faced by people with HIV and STIs in those settings. Where people with HIV have a good and trusted GP or dentist, this is a major positive contribution to their overall health and welfare.

CHARGING FOR TREATMENT

7. The current NHS policy of charging certain groups of people resident in the UK for hospital and outpatient treatment is a major source of health inequality. People refused asylum but remaining in the UK because their country of origin is too dangerous for deportation, and other undocumented but resident migrants, are currently charged for all hospital treatment. There is no data to show that this system is working and, indeed, a previous Health Select Committee Inquiry on Sexual Health in 2005 recommended that charging for HIV be scrapped on the grounds of both public health and the public purse. HIV is the only STI which is not exempted from the charging regulations for public health reasons—itsself an inexplicable inequality.

8. However, we understand that the Government is planning shortly to announce not the reduction but the extension of charging, to also cover primary care. This will, amongst other impacts, greatly exacerbate health inequalities for some migrants.

9. While the Government states that immediately necessary treatment should always be given, with charges being made later (in particular for maternity services), it is THT's experience and that of the people we support that this is often not happening. Again, THT can give case studies of people who have been refused maternity and other services unless they pay in advance; people who have been wrongly told that they must pay; and people who have abandoned needed treatment because they cannot pay.

10. This system is particularly inequitable because those administering it are often untrained and inexperienced and there is no monitoring of their decisions by the DH. THT has experienced people eligible for free treatment being refused; people being treated freely by one hospital and not another; and people reluctant to ask for treatment because of the fear and shame of refusal. An extension to primary care is likely to increase these inequalities.

11. THT submits that reform of the charging scheme, based upon evidence of efficacy and consideration of public health impact, would do much to address a considerable area of health inequality currently being perpetuated.

YOUNG PEOPLE'S SEXUAL HEALTH

12. The sexual health of young people in the UK is amongst the worst in Western Europe, in terms of teenage pregnancy rates and sexually transmitted infections. There are clear health inequalities within this based upon geography, social class and educational attainment.

13. THT believes the NHS has a major role to play within the reduction of this problem. Many young people gain little accurate information at home or in the schoolroom about sexual health, though they are often subject to considerable misinformation within their peer group. In the absence of compulsory comprehensive Sex and Relationships Education, a school nurse in every school, supplied by the Primary Care Trust or Health Board and trained to give confidential advice and support to young people as they grow to adulthood and are faced with sexual choices, would have a major role to play.

14. The NHS also has a role to play in supporting peer education initiatives amongst young people which seek to dispel misinformation and provide young role models for sexual health improvement, such as THT's Young Leaders Project which was recently commended by the Prime Minister as "inspirational". Joint work with these initiatives not only benefits the young people involved but also provides the NHS with useful insights into the priorities and needs of young people around their sexual health, which in turn can be used to further reduce health inequalities.

COST EFFECTIVENESS OF TARGETED HIV PREVENTION INITIATIVES.

15. With the rise in availability of effective treatment for HIV in the last decade there has been a more than unfortunate decrease in the local funding allocated to, and the relative priority accorded to the prevention of onward transmission of HIV. However, there is a very strong case for the cost effectiveness of some targeted interventions to prevent HIV transmission.

16. The DH's National Strategy for Sexual Health & HIV states that the lifetime cost per case of HIV in the UK is around half a million pounds per transmission. The National Institute for Clinical Excellence has considered the efficacy of HIV prevention technologies and interventions and has stated that there is good evidence for the efficacy of a range of HIV prevention interventions, from condom useage to groupwork.

These interventions are considerably less expensive than ongoing transmissions, and yet the current emphasis within NHS planning at a local level is often to deprioritise HIV and STI prevention. This is demonstrated by the way in which Government money allocated to PCTs in England for sexual health and HIV work in the past two years was widely diverted to other priorities, as documented by the Sexual Health & HIV Independent Advisory Group and others.

17. THT believes that commissioners of sexual health services within PCTs need improved guidance and in-service training from the NHS, or the DH, in order to be able to plan and negotiate HIV and sexual health services locally that are evidence based and cost effective.

January 2008

Memorandum by H·E·A·R·T UK (HI 73)

HEALTH INEQUALITIES

EXECUTIVE SUMMARY

1. Coronary heart disease (CHD) is the biggest killer in the UK, and cholesterol is the single greatest risk factor for developing CHD. Cholesterol contributes to almost half of all coronary heart disease related deaths in the UK. High levels of cholesterol, and the associated risk factors including heart disease and stroke, are intrinsically linked to health inequalities. It also contributes to the increased risk of cardiovascular disease associated with diabetes and obesity.

2. People on low incomes are at greatest risk of developing cardiovascular disease: the highest levels of cholesterol are evident in areas with greater deprivation, where poor diets, smoking, obesity and inactivity are commonplace. This was illustrated by the results of the Flora "Test the Nations' Hearts" survey (Flora pro.activ, 1996), which found that over half of all adults tested (56%) had cholesterol levels above the recommended level, and identified Glasgow and Huddersfield as the 2 UK cities with the highest cholesterol levels and the highest percentage of residents with above optimal blood pressure. Other cities with high percentages included Sheffield and Middlesbrough.

3. H·E·A·R·T UK, the cholesterol charity, is a nationwide charity that aims to raise awareness about the importance of cholesterol management with both patients and healthcare practitioners. The charity helps families with a high risk of premature cardiovascular disease, particularly those with some form of inherited high cholesterol. However, up to 85% of people with inherited high cholesterol are undiagnosed, and are therefore not undergoing treatment.

4. H·E·A·R·T UK believes that the health service has a vital role to play in tackling the health inequalities associated with high cholesterol, and that a public health campaign on the dangers of cholesterol is needed to tackle this growing problem. This is becoming increasingly important in light of the ageing population, and the Government's desire to keep people in work for longer.

5. In order to tackle health inequalities, H·E·A·R·T UK believes that a long-term Department of Health strategy on public health is required, including a public education campaign on fats, greater awareness of the risks associated with high cholesterol, and wider availability of high quality cardiovascular risk testing including full cholesterol profile. In addition, H·E·A·R·T UK is calling for the implementation of the latest clinical standards of cardiovascular disease management for high risk groups, and for these to be incorporated in the QOF targets on cholesterol. The charity also supports the need for better training for healthcare professionals in the primary care setting on providing diet and lifestyle advice, in order to empower the patients to take action to improve their heart health. NICE is currently in the early stages of producing guidance on the prevention of cardiovascular disease at the population level. As a registered stakeholder, H·E·A·R·T UK believes that this guidance must specifically look to address health inequalities.

The extent to which the NHS can contribute to reducing health inequalities, given that many of the causes of inequalities relate to other policy areas eg taxation, employment, housing, education and local government

6. If the government is to meet its target of keeping more people in work for longer, it must address the health issues that affect people's capacity to continue working, and to help those most at risk of suffering from ill-health or disablement as a result of deprivation or poverty. For this reason, the NHS has a pivotal role to play in reducing health inequalities.

7. A recent report by H·E·A·R·T UK ("*Cholesterol and the ageing population: Avoiding the crisis in health and pension costs*", 2007) found that the Government's plans to raise the age of retirement and keep people working longer are under threat as a result of increased ill health and incapacity. The report found that by 2020, CHD disease will be the leading cause of disablement in the UK. The report also highlighted the findings of the 2002 economic study, "*The economic burden of coronary heart disease in the UK*", which found the annual cost of cardiovascular disease to the UK economy was around £7 billion.

8. People on lower incomes are shown to be at greatest risk of developing cardiovascular disease, and it is these people who will be hit hardest by an inability to work as a result of CHD related incapacity. In addition, once diagnosed people on lower incomes may struggle to pay for the long-term treatments recommended to them, leading to low compliance with medication and elevated risk of suffering an event as a result of their condition. H·E·A·R·T UK believes greater consideration should be given to widening the exemptions for prescription charging.

9. A long term strategy on public health is needed, led by the Department of Health. This must include a public education campaign on fats, greater awareness of the risks associated with raised cholesterol and wider availability of high quality cholesterol and heart risk assessment.

10. NHS healthcare practitioners are also well placed to tackle health inequalities, particularly in primary care. This is because primary care is often the public face of the health service, and has regular contact with patients. Patients also trust their primary healthcare professionals to help them to make informed choices about their health and to discuss treatment options.

The distribution and quality of GP services and their influence on health inequalities, including how the Quality and Outcomes Framework and Practice-based Commissioning might be used to improve the quality and distribution of GP services to reduce health inequalities

11. The role of primary care in addressing health inequalities is paramount. As the first point of call for many members of the public who are seeking healthcare advice, primary care is uniquely placed to educate patients about the risks of cardiovascular disease and to assess individuals for their overall risk by measuring blood cholesterol, blood pressure, blood glucose, body mass index, family history, etc. The primary care team is well placed to offer services and support for preventative action and treatment, as necessary, for the majority of patients—only those at highest risk and with complex conditions such as familial cholesterol conditions may require referral to specialist care.

12. In recent years, there have been some significant advances in treating high blood cholesterol in the primary care setting, including the introduction of the GP contract and an increased prescribing of cholesterol lowering statin drugs. However, the potential for the Quality and Outcomes Framework to prevent CVD is compromised as a result of the outdated target value for cholesterol included in the current contract. The latest clinical guidance from the Joint British Societies (JBS2) and the Scottish Intercollegiate Guideline Network recommended a significantly lower target of blood cholesterol to be introduced for high risk groups. Currently high risk patients are being treated to a target of 5mmol/l of cholesterol and 3mmol/l of LDL cholesterol. However, the JBS2 guidance recommended that these targets should be revised to 4mmol/l of cholesterol and 2mmol/l of LDL cholesterol. Failure to update the guidance has also compounded the “treatment gap”, where the number of people currently being prescribed cholesterol lowering drugs is considerably less than the number who could benefit from treatment, and the target level for those receiving the drugs is usually well below the cholesterol level actually achieved. It is estimated that more than 7,000 heart attacks a year are attributable to the treatment gap. Therefore the QOF must be allowed to evolve in order to reflect evidence based best practice care and to improve the care provided to the patients.

13. In addition, we understand anecdotally from our discussions with patients that the provision of care varies considerably between GP practices. It is our understanding that few practices will provide cholesterol tests to patients if the patient is not considered to be “at risk”. Many of the pharmacies that offer testing also charge a small fee, making it more difficult for the people with the greatest need (ie those with lower incomes) to access their risk. The JBS2 guidelines recommends opportunistic testing should be introduced, including regular testing for people over the age of 40—funded by the GP contract—to allow patients, regardless of their background, to be made aware of their cholesterol levels. NICE is also in the process of developing a clinical guideline on lipid modification, which is due to be published this year. This will include guidance on identifying people at risk of CVD through primary care.

14. There is some evidence of innovative practice, including practitioners taking testing into the community by testing people in pubs and community centres to reach at risk groups. However, such practices are not widespread. In order to lower cholesterol levels, the first line of action should always be through diet and lifestyle, by reducing the intake of saturated fat, stopping smoking and taking more exercise. Every healthcare professional within the primary care setting has an important role to play here, including practice nurses who are now trained with skills in lifestyle modification, and specialist advice from dietitians and health visitors. The doctors should take responsibility to ensure that their practice has mechanisms in place to provide diet and lifestyle advice, and to appoint all members of the practice with a specific role. In the long term, such action within primary care can improve patient health by empowering the patient to make the right choices about their own health, as well as significantly reducing the burden on secondary care.

The effectiveness of public health services at reducing inequalities by targeting key causes such as smoking and obesity, including whether some public health interventions may lead to increases in health inequalities; and which interventions are most cost effective

15. Despite clear signals from the Government that it was seeking to improve public health, including the publication of the 2004 White Paper, *“Choosing Health, Making Healthy Choices Easier”*, implementation of the recommendations has been slow and patchy.

16. H·E·A·R·T UK’s 2007 report concluded that the UK’s public health policies were making very little impact on reducing health inequalities, and were actually widening the gap between the North and South of England. This was also recognised in the 2006 Department of Health report *“Health Profile of England”*. A report by the London Health Observatory in November 2006 (*“London Health Inequalities Forecast”*) found that the inequalities gap in deaths from heart disease and stroke in London was widening, and concluded that the Government’s targets on reducing health inequalities would not be met unless the Spearhead PCTs in London provided services such as the detection of high blood pressure and cholesterol.

17. In the UK, the Government’s public health policies have fallen well short of their targets. However, evidence from overseas clearly demonstrates that Government-led campaigns can be very successful in helping to tackle public health issues including CHD.

18. In the 1960’s, Finland suffered from the highest death rate from CHD in Europe. The North Karelia project was launched in 1972 as a collaborative project driven by community initiatives and led by the national Government in order to address this issue. As part of the scheme, which started in the province of North Karelia, a number of activities were established including programmes in the workplace to lose weight; cholesterol lowering competitions between villages; a national television series to chart the progress of volunteers to lead a healthier lifestyle; collaborative action with food manufacturers and supermarkets to encourage dietary changes; and educating key community leaders to encourage them to pay attention to health related issues.

19. The results of this project were remarkable. Cardiovascular mortality rates for men aged between 35 and 64 decreased 57% from 1970 to 1992; the number of people using butter on their bread fell from 90% in 1972 to just 15% in 1992 whilst the consumption of whole milk fell from 70% to 14%; and annual fruit and vegetable consumption increased from about 20kg per person in 1972 to around 50kg in 1992. Moreover, in 1972 just 28% of men and 42% of women reported having their blood pressure measured in the previous 6 months. By 1993, over 98% of the population had had their blood pressure measured.

20. Other international examples of note include the successful Australian Heart Foundation Tick Programme Campaign, where food products and meals eaten out of the home received a tick if they met the healthy heart criteria. This campaign helped to inform the public about the importance of a healthy heart diet.

21. The US National Cholesterol Education Programme (NCEP) is a further example of how public health policies can successfully address management of risk factors with beneficial outcomes. NCEP started in 1985 to help to tackle CHD by reducing the number of Americans with high blood cholesterol. The NCEP has successfully highlighted a broad range of risk factors and provided comprehensive management guidelines for both the public and healthcare professionals. This resulted in a 23% increase in the number of people screened for cholesterol in the US between 1991 and 2003. If a similar scheme was introduced in the UK it could lead to widespread changes in health behaviour by making people aware of the risks associated with high cholesterol and poor diet. It could further result in increased intervention for those at risk.

22. In the UK the Food Standards Agency has recently consulted on a draft saturated fat and energy intake programme, which H·E·A·R·T UK responded to. H·E·A·R·T UK believes that this strategy must take into account health inequalities, and actively seek to address the issue as part of the programme. It is anticipated that the programme will be rolled out during the course of this year.

23. Despite action by the UK Government to raise awareness about the dangers of heart disease, many people are still unaware about the importance of low blood cholesterol. Indeed, an estimated 85% of people with some form of inherited high cholesterol remain undiagnosed and untreated. In 2004 Cholesterol UK—a joint initiative of H·E·A·R·T UK and the British Cardiac Patients Association—carried out a survey in which less than 5% of respondents identified cholesterol as the highest risk factor for CHD, but 90% said they would be fairly or very concerned to learn that their blood cholesterol was too high. This clearly demonstrates a need for a focused public health campaign from government to raise awareness of this issue, to ensure that those in need of treatment are receiving it and that people are taking appropriate action to ensure their cholesterol levels remain low. Any such campaign should be implemented in partnership with charities and community initiatives etc to ensure that it is far reaching.

Whether specific interventions designed to tackle health inequalities such as Sure Start and Health Action Zones, have proved effective and cost effective

24. H·E·A·R·T UK supports specific action to tackle health inequalities and the diseases readily associated with this. As identified in the answer above, we believe that a public health campaign to raise awareness of cholesterol is needed in order to tackle CHD.

25. H·E·A·R·T UK's 2007 report, "*Cholesterol and the Ageing Population*" also identified 3 other areas of immediate activity for the government, including greater access to cholesterol testing as part of the NHS heart risk assessment to help people understand their own heart health; implementation of latest clinical standards on cardiovascular disease management or high risk groups; and better training for health professionals in the primary care setting on diet, public health measures and prevention of heart disease. H·E·A·R·T UK believes that these measures are the most effective way of increasing public awareness about cholesterol and CHD, and consequently tackling health inequalities.

The success of NHS organisations at coordinating activities with other organisations, for example local authorities, education and housing providers, to tackle inequalities, and what incentives can be provided to ensure these organisations improve care

26. At a local level greater coordination with local authorities, education and housing providers would be of significant benefit to the population. However, as recognised in H·E·A·R·T UK's 2007 report, "*Cholesterol and the ageing population*", frequent reports about PCTs across the country suggest that the organisations are more inclined to divert money away from such activities in order to reduce waiting lists or deficits. Indeed, the GUM clinic spending report on Sexual Health & HIV, published July 2006, revealed that just 15% of PCTs were spending money as allocated to them by the Government to implement the 2004 White Paper, "*Choosing Health*".

CONCLUSIONS

27. A long-term Department of Health strategy on public health is needed to tackle health inequalities. This must include a public education campaign on fats; greater awareness of the risks associated with raised cholesterol; and wider availability of high quality cholesterol and heart risk assessment. Comparisons from overseas clearly demonstrate the positive impact that government-led public health campaigns can have on helping to address this issue.

28. QOF has the potential to make significant improvements to the care of patients at risk of CVD, but only if the targets reflect evidence based best practice care for patients, and not outdated targets that compound the treatment gap.

29. In addition, better training of healthcare professionals in the primary care setting to provide diet and lifestyle advice to patients is required. GPs, practice nurses, dietitians and health visitors all have an important role to play here, and it would empower the patients to make positive choices to improve their own health.

January 2008

Memorandum by Every Disabled Child Matters (HI 74)

HEALTH INEQUALITIES

ABOUT EVERY DISABLED CHILD MATTERS

1. Every Disabled Child Matters (EDCM) is the campaign to get rights and justice for every disabled child. We have been working to raise the political profile of disabled children and their families, and campaigning to get the services and support they need to lead ordinary lives.

2. EDCM is a consortium campaign with four members operating as equal partners:

- Contact a Family
- Council for Disabled Children
- Mencap
- Special Education Consortium

3. Between them, the campaign partners work with and represent all of the 770,000 disabled children and young people in the UK, and their families.

4. EDCM held a series of Parliamentary Hearings on services for disabled children during summer 2006. In October 2006 a report was published⁵⁷⁰ which sets out the evidence taken during the hearings. All quotes below are taken from that report.

EXECUTIVE SUMMARY

5. There are around 700,000 disabled children in Great Britain with a diverse range of needs. The numbers of disabled children are growing—particularly those born with complex health needs, and many more disabled children are surviving into adulthood. This presents a challenge to all statutory services involved in meeting the needs of disabled children.

6. Disabled children and their families want to lead “ordinary lives”. To do this, they require support from a range of services, including health services. For disabled children, health inequalities are directly determined by the extent to which NHS agencies can provide access to universal and specialist health services.

7. Unfortunately, the evidence suggests that families have poor experiences of health services. Parents report that universal health services are inaccessible and access to specialist services is variable across the country.

8. The direction of central government policy is right, with an emphasis on early intervention—crucial for improving outcomes of disabled children. However much more needs to be done to translate policy into practice on the ground.

9. There are several specific areas that require attention to address health inequalities experienced by disabled children, set out in more detail below. However, full implementation of Standard 8 of the National Service Framework for Children, Young People and Maternity Services⁵⁷¹ (standard on disabled children and those with complex health needs), will go a long way to addressing the health inequalities experienced by disabled children.

INTRODUCTION

Disabled children population

10. There are around 700,000 disabled children under 16 in Great Britain⁵⁷². In the past ten years, the prevalence of severe disability and complex needs has risen. This is due to a number of factors, including increased survival of pre-term babies and increased survival of children after severe trauma or illness. There are up to 6,000 children living at home who are dependent on assistive technology.

11. Children and young people with life-limiting conditions, such as cystic fibrosis, have better life expectancy and improved quality of life, due to improved treatment and support. The number of children identified with autistic spectrum disorders has risen over the last ten years.

Disabled children and health inequalities

12. For disabled children, health inequalities are directly determined by the extent to which NHS agencies can provide access to universal and specialist health services.

13. An investigation by the Disability Rights Commission⁵⁷³ revealed “an inadequate response from the health services and governments in England and Wales to the major physical health inequalities experienced by some of the most socially excluded citizens: those with learning disabilities and/or mental health problems.” This included disabled children and young people. The investigation found children and young people in particular is the experienced “diagnostic overshadowing”—that is reports of physical ill health being viewed as part of the mental health problem or learning disability—and so not investigated or treated.

⁵⁷⁰ Parliamentary Hearings on Services for Disabled Children—www.edcm.org.uk/parliamentary

⁵⁷¹ Department of Health and Department for Education and Skills (2004).

⁵⁷² Family Resources Survey 2002–2003.

⁵⁷³ Equal Treatment: Closing the Gap A formal investigation into physical health inequalities experienced by people with learning disabilities and/or mental health problems.

Key challenges

14. Disabled children require services from both universal and specialist health services. Despite their crucial importance, families frequently report that universal health services are inaccessible.

15. Families also experience a postcode lottery in accessing specialist health services. Submissions to the Parliamentary Hearings expressed a high level of dissatisfaction with the services that disabled children and their families receive from health, social care and education services. Parents and professionals described health services as follows:

Good:—parents 16 %, professionals 19%

Adequate:—parents 36%, professionals 46%

Poor:—parents 48 %, professionals 35%

Early intervention

16. Intervening early is crucially important in improving outcomes for disabled children—in terms of both promoting development and minimising decline or regression among children with developmental disabilities.

17. Government has recognised this: early intervention is emphasised in Standard 1 of the Children's National Service Framework, which states "The health and well-being of all children is promoted and delivered through a co-ordinated programme of action, including prevention and early intervention, wherever possible, to ensure long term gain."

18. However, many young disabled children are being excluded from early childhood services because they are being denied the right equipment or because staff lack training and expertise to deliver interventions. Specific interventions are addressed below.

Recent developments—a national health priority

19. In the last year the Department for Children, Schools and Families have confirmed disabled children as a priority through new investment in services totaling £430 million—announced in both the *Aiming High for Disabled Children review*⁵⁷⁴ and the Children's Plan⁵⁷⁵.

20. No specific funding commitments have yet been made by the Department of Health. However, in a recent letter⁵⁷⁶, Health Minister Ivan Lewis MP states that disabled children are "at the heart of the Every Child Matters agenda" and confirms that "new growth funding has been included in PCT baseline allocations to enable PCTs to work with local authorities to significantly increase the range and number of short breaks".

21. Disabled children have also been included as one of four local priority groups for service improvement in the NHS, through the operating framework announced in December 2007⁵⁷⁷. This is the first time that disabled children have been a priority group for the NHS and demonstrates central government's recognition that much more needs to be done to meet the health needs of disabled children.

22. The points below specifically address the terms of reference of the inquiry

The extent to which the NHS can contribute to reducing health inequalities, given that many of the causes of inequalities relate to other policy areas eg taxation, employment, housing, education and local government

Access to hospital / primary health care services

23. Disabled children often attend the same hospital two or three times in the same week; this can affect the family's wider health needs and be disruptive to family, school and working life. Those children and young people who find it hard to wait for long periods in waiting rooms often cannot get primary care appointments that meet their needs—this has to change.

⁵⁷⁴ Aiming high for disabled children: better support for families (May 2007), HM Treasury & Department for Education and Skills.

⁵⁷⁵ The Children's Plan: Building brighter futures (December 2007) Department for Children, Schools and Families.

⁵⁷⁶ Ministerial letter of 19/12/2007 to local authority and primary care trust chief executives setting out the full Comprehensive Spending Review settlement in relation to priorities for disabled children's services.

⁵⁷⁷ The NHS in England: The operating framework for 2008–9 (December 2007) Department of Health.

⁵⁷⁸ Don't push me around! Disabled children's experiences of wheelchair services in the UK, Neera Sharma with Jan Morrison.

Equipment and wheelchair services

24. Equipment services are severely stretched and underfunded. A joint report by Barnardo's and Whizz Kidz⁵⁷⁹ states: "Despite a policy and legislative framework that supports better mobility provision, and evidence of the importance of mobility in a child's development, the experience of many disabled children is that the NHS does not provide them with a wheelchair that meets their needs . . . This can slow their development and limit their capacity to take part in everyday activities."

25. This report highlights the under-funding of wheelchair services, which has led to strict eligibility criteria. This often discriminates against young children in particular, leading to inadequate or no provision. Additionally, provision focuses too heavily on clinical need and often fails to take into account a child's individual developmental, educational and social needs.

26. Time and again children who need multiple equipment items are subject to scandalous delays because of resistance to the funding of sometimes paltry amounts.—Health professional.

Commissioning specialist health services

27. A major issue in health services is the commissioning of specialist services. This is particularly important for children who have continuing care needs. The Children's Trust told the Parliamentary Hearings that

"present systems designed to address multifaceted complex health needs seem extraordinarily complex and present too many examples of failure with inadequate clarity about who is responsible for what, resulting in bureaucratic and time-consuming turf wars, sometimes over small amounts of money."

The distribution and quality of GP services and their influence on health inequalities, including how the Quality and Outcomes Framework and Practice-based Commissioning might be used to improve the quality and distribution of GP services to reduce health inequalities

Diagnosis and assessment

28. Despite improvements in diagnostic services, too many families are still struggling to get a confirmed diagnosis of their child's disability.

29. My son took years to get final diagnosis, we fought and fought to get things sorted out in school, no one would listen until it was too late, and now he has been home for three years, when he should have been able to go to school and be with his peers.

30. In our experience diagnosis has been deliberately withheld and private diagnosis ignored so as to avoid the cost of services.

31. Why does it take three years to get a diagnosis of autism in some parts of the country and in others it's within six weeks?

32. Just as critical for families is the delivery of appropriate information at the point of diagnosis. One family who recently received a diagnosis for their child was given nothing but a photocopied excerpt from a medical textbook by their paediatrician.

33. This did nothing to answer our many questions, in fact it raised some more (such as mention of "survival", an issue we never even dreamt we would have to be thinking about).

The success of NHS organisations at co-ordinating activities with other organisations, for example local authorities, education and housing providers, to tackle inequalities; and what incentives can be provided to ensure these organisations improve care

Access to child and adolescent mental health services

34. Many children and young people with complex health needs or life-limiting illnesses need psychological and emotional support to minimise stress. In addition, these children and young people are significantly more vulnerable to mental health problems than other children.

35. Disabled children have often found it difficult to access child and adolescent mental health services. There have been particular difficulties for children and young people who have autistic spectrum disorders or learning disabilities.

36. Children who have a learning disability are not often accepted into the Child and Adolescent Mental Health Service (CAMHS) because some of the CAMHS staff do not feel that they are equipped with the skills to work with children who have a learning disability.—Health professional.

⁵⁷⁹ Don't push me around! Disabled children's experiences of wheelchair services in the UK, Neera Sharma with Jan Morrison.

Access to therapy services

37. Children's and young people's access to rehabilitation and therapy services is inconsistent across regions, with long waits in some areas. Waiting long periods for rehabilitation and therapy can greatly harm the educational attainment and wider development of individual children and young people, including loss of function and ability. Therapy services may include speech and language therapy, occupational therapy and physiotherapy.

38. In my LA children receive therapy services until they are five years old and then they stop. The health service do not have enough therapists to provide continuity of service after five years, whilst they admit that many children continue to have needs. They simply choose not to prioritise in this way.—Education professional.

39. Because the focus for children's services is education-led, the therapeutic health needs of children are taking a very low profile in PCTs.—Health professional.

40. Our service (Occupational therapy) is only able to address a fraction of children's needs to participate in daily life activities due to scarce resources.—PCT occupational therapy team.

Workforce

41. A major issue in accessibility of universal services—including health services—is staff training in disability awareness.

42. There is a lack of understanding in universal services about disabled children . . . there is still a belief held by some health professionals that disabled children are not eligible for the universal offer.—Professional.

43. In particular, there are a lack of specialist health visitors able to identify problems early and provide appropriate support and advice to families.

Transition to adulthood

44. There is much evidence that adult health services are unable to meet the needs of disabled young people.

45. Evidence to the Parliamentary Hearings showed that transition in health services was felt to be particularly abrupt, with young people suddenly losing access to key specialists who may have worked with them throughout their childhood.

46. Since turning 18, I have been horrified at the health services which my son recently received when he was hospitalised.—Parent.

47. Families often report receiving excellent care from specialists such as the community paediatrician and child health team; they are shocked when this model of care stops at transition to adulthood.—Foundation for People with Learning Disabilities.

48. Families who may have had consistent contact with specialist health services while their disabled child was younger have to access primary care services to try to get similar specialist support from adult services.

49. Having just gone through transition period found health services totally lacking and unhelpful. For example had to have referral from my own GP who has not seen son for years to be referred to go and have specialist foot wear. There was no co-ordination when he left school for this to happen.—Parent.

50. There can be huge problems with transition when there is no designated consultant to hand over to and therapies essentially stop.—Health professional.

EDCM RECOMMENDATIONS

Full implementation of Children's NSF Standard 8

51. Standard 8 of the Children's NSF sets out standards for health and social care services for disabled children and those with complex health needs.

52. It's vision is that:

“Children and young people who are disabled or who have complex health needs receive co-ordinated, high-quality child and family-centred services which are based on assessed needs, which promote social inclusion and, where possible, which enable them and their families to live ordinary lives.”

53. Full implementation of Standard 8 will go a long way to addressing the health inequalities experienced by disabled children.

Improving transition to adult health services

54. Health agencies must actively contribute to the multi-agency transition planning process. Particular attention should be paid to ensuring that the needs of disabled young people in transition to adulthood are met through the development of care pathways in health services.

Early identification and intervention

55. Multi-agency assessment of need is essential as the catalyst for early intervention. Health and local authority partners also need to plan together to identify and meet the needs of children with low incidence and rare conditions.

56. Health agencies should ensure that diagnostic services are available at a local and/or regional level to deliver prompt and accurate diagnoses for every disabled child. The Early Support⁵⁸⁰ model should be used and extended to ensure that all parents receiving a diagnosis should receive appropriate information related to their child's condition, including contact details for support organisations.

Access to universal primary care services

57. Appointments are arranged to meet the individual needs of child and family. For example: Hospital departments and clinics synchronise their appointment systems as far as possible, to minimise the number of visits; children are offered appointments at school or outside school hours, to ensure a minimum absence from school, and systems are in place to support children who find it hard to wait.

Provision of equipment and wheelchairs

58. Provision is timely and disabled children are able to use/access the equipment and assistive technology they need in all places they typically spend time (eg school, home, short-term care settings). Equipment and assistive technology is tailored to the individual needs of the child and their future development.

Commissioning services

59. Services for disabled children should be jointly commissioned, using the children's trust model as a basis for developing joint working. To spread risk, commissioning could be done at a regional level, with accountability jointly to Strategic Health Authorities and regional Government Offices.

January 2008

Memorandum by the Oxford Health Alliance (HI 75)

THE CONTRIBUTION OF THE NHS TO REDUCING HEALTH INEQUALITIES

1. EXECUTIVE SUMMARY

1.1 This response focuses on the three major risk factors for chronic disease—tobacco use, poor diet and lack of physical activity. There are significant inequalities between socioeconomic groups in the UK both in terms of disease prevalence (CVD, type 2 diabetes, many cancers and chronic lung disease) and the behaviours that lead to the diseases. Preventing chronic disease, therefore, requires tackling any inequalities that discourage healthy decision-making.

1.2 This response focuses on the drivers of chronic disease and how healthy lifestyles can be encouraged, including by the NHS.

2. THE OxHA APPROACH TO HEALTH INEQUALITIES⁵⁸¹

2.1 The Oxford Health Alliance (OxHA) is a global charity registered in England and Wales that works to reduce the global epidemic of chronic disease (CVD, type 2 diabetes, many cancers and chronic lung disease) through tackling three major risk factors—tobacco use, poor diet and lack of physical activity. There are significant inequalities between socioeconomic groups in the UK both in terms of the disease prevalence and

⁵⁸⁰ Early Support is the Government's recommended approach to co-ordinating services across England for young disabled children and their families—see www.earlysupport.org.uk

⁵⁸¹ There are, of course, radically different inequalities issues between developed and developing countries—but this response concerns the UK and the contribution of the NHS and other factors.

the behaviours that lead to the diseases (see appendix 1). Preventing chronic disease, therefore, requires tackling any inequalities that discourage healthy decision-making. For example, of particular concern to OxHA—given its focus on the three risk factors—are:

2.2 Tobacco use:

- In 2004, the *Health Survey for England 2005: The Health of Minority Ethnic Groups* shows that 40% of Bangladeshi men, 29% of Pakistani men and 20% of Indian men smoke⁵⁸² compared with a national average for the whole population of 24% of adult men.
- According to ASH (Action against Smoking and Health), smoking is the major cause of health inequalities in the UK accounting for two-thirds of the difference in risk of premature death between social classes.
- Death rates from tobacco are two to three times higher among disadvantaged social groups than among the better off (ASH).
- Long-term smokers are disproportionately drawn from lower socio-economic groups. People in poorer social groups who smoke, start smoking at an earlier age: of those in managerial and professional households, 31% started smoking before they were 16, compared with 44% of those in routine and manual households (ASH).

2.3 Poor diet:

- According to the Health Survey for England 2002, 10% of girls in households where the reference person worked in routine or semi-routine occupations eat the recommended number of portions compared to 14% in managerial/professional households. For boys the respective figures were 9% and 14%.
- According to the Food Standards Agency Low Income Diet and Nutrition Survey, men and women with a lower level of educational achievement tended to have a “less healthy” diet, eating fewer vegetables and more chips, fried and roast potatoes.

2.4 Physical activity:

- 88% of men in the highest income quartile took part in some form of physical activity each month (on an average of 13.5 days); this drops to 66% on an average of 10.2 days each month for those in the lowest income quartile⁵⁸³

2.5 Obesity:

- 61.5% of women with routine/manual jobs have a BMI of over 25; this is significantly higher than the 49.8% among those in managerial/professional occupations⁵⁸⁴

3. COMMENTS ON THE DRIVERS OF HEALTH INEQUALITIES

3.1 OxHA believes that chronic disease prevention is dependent on keeping people healthy (ie encouraging lifestyle change) rather than treating those who are ill; therefore, along with the role the NHS plays, there are many drivers that are (as noted in the Terms of Reference of this Select Committee Inquiry) outside its remit. In fact, the NHS is only one of many stakeholders responsible for ensuring that the healthy choices become the easy choices, and it must work side-by-side with other partners in order to achieve this aim.

3.2 For example, a good diet requires that healthy, fresh foods (not high in fat, sugar and salt) should be:

- *accessible*—those on low incomes may not live near supermarkets or other shops that sell fresh fruit and vegetables—and if local areas are perceived as unsafe, or if public transport is insufficient, it may be difficult to access the foods in supermarkets
- *available*—local corner shops may simply not stock good-quality fresh foods
- *appropriate*—foods locally may not be culturally appropriate for those from ethnic minorities
- *affordable*—the healthy options may not be the cheapest options—particularly for those on low incomes, the relative low cost of calories from HFSS foods means that they are the most likely to be purchased.

3.3 Although the NHS does not play much of a role in the above, it does play a role in making individuals aware of the impact of a poor diet on their health as well as helping them understand how they can go about changing their behaviour. For example, health professionals must be confident in talking to their patients about their weight and possible risk of disease if they do nothing to improve their lifestyles.

⁵⁸² http://www.ic.nhs.uk/webfiles/publications/healthsurvey2004ethnicfull/HealthSurveyforEngland210406_PDF.pdf

⁵⁸³ <http://www.ic.nhs.uk/webfiles/publications/opan06/obesity%2C%20physical%20activity%20and%20diet%20tables.xls> table 4.3

⁵⁸⁴ <http://www.ic.nhs.uk/webfiles/publications/opan06/obesity%2C%20physical%20activity%20and%20diet%20tables.xls> table 2.3

3.4 There is, indeed, a danger that spending money on public health interventions that rely solely on education (eg social marketing campaigns) rather than structural changes could increase inequalities, as raising awareness among the least-well off may not be sufficient, so only those on higher incomes will be able to make the lifestyle changes. Similarly, raising taxes on tobacco products may discourage smoking—but among those who are not able to give up the habit, it will take up a higher proportion of the income of those on low earnings.

3.5 For change to reach all incomes, a raft of measures would be needed: ensuring a good land-use mix (eg planning for local shops near residential areas), encouraging farmers' markets and other ways of distributing healthy foods locally, providing good public transport links where there are no local shops, and making the streets safe for travelling.

3.6 Similarly, opportunities for physical activity require:

- *safe streets*—walking and cycling are two of the most popular forms of exercise, but many people (particularly those with children) do not regard the streets as safe enough to use
- *access to green spaces*—preferably on foot, or with good public transport access
- *affordable leisure/sport opportunities*—for example, local swimming pools and recreation grounds, that are cheap and safe for children and adults alike
- opportunities for physical activity at work (where jobs are sedentary) and at school.

3.7 The NICE Guidelines on obesity touch on many of these issues, and provide a model for other countries as well as the UK, as they take a whole-systems approach to tackling the problem—looking at the role of the NHS but also of employers, the education system, urban planners and others. As the Terms of Reference state, many of these issues are beyond the reach of the NHS, but this is no reason for the NHS not to get involved.

4. SUGGESTIONS FOR THE ROLE OF THE NHS

4.1 While the role of the NHS in facilitating healthy lifestyles may be limited, there are, of course, things that can be done.

- Set a good example! The NHS is the country's largest employer, employing more than 1.3 million people, so it is well placed to lead by example. In addition, if nurses, doctors and others have made changes to their own lifestyles, they will be better able to advise—and talking to people about the importance of changing lifestyles is a strong driver for change, especially when 80% of all GP visits are chronic disease-related.
- Any public-health campaigns should pay particular attention to the needs of the less advantaged and ethnic minorities, in order in order to avoid widening relative inequalities in smoking and smoking- or diet-related health outcomes.

5. WHAT WORKS?

5.1 The Oxford Health Alliance is currently piloting a new initiative, Community Interventions for Health, which will measure the impact of a series of interventions (in workplaces, schools, local communities and healthcare centres) across sites in four countries—in cities in China, India, Mexico and England.

5.2 The CIH programme will have the following components:

- *Community coalition-building*—key stakeholders will work together to encourage healthy lifestyle change throughout the community, such as advocating for bicycle paths and smoke-free environments or creating farmers' markets
- *Health education*—dissemination of health messages, such as the training of health professionals, using mass media, social marketing or peer educators.
- *Structural change*—structural interventions such as advocating for and implementing policy change, environmental change (improving opportunities for physical activity in schools and workplaces) and economic change (reducing taxes on healthy foods). These components interact to create communities in which the healthy choices are the easy choices.

5.3 With regards to healthcare settings, the following (proven successful) structural interventions, among others, will be put in place:

- provide healthy meals in canteens and vending machines;
- revise health assessments to include diet and physical activity questionnaires;
- provide better training for healthcare professionals to advise patients on healthy diet;
- create places for access to physical activity;
- promote walking/ bicycling to healthcare settings instead of using cars;
- train healthcare professionals to prescribe exercise.

5.4 Each site programme will reach 5,000 people directly and—it is hoped—many more indirectly, and the interventions will be evaluated. These interventions will focus on tobacco control, and encouraging healthier diets and more physical activity. The intervention site in England (Leicester) is a relatively deprived area, and we hope that the interventions will have a significant impact upon the socio-economically disadvantaged.

January 2008

Appendix 1

Percentage of employees of different socio-economic groups exhibiting individual lifestyle risk factors						
Percentage	I (professional)	II (intermediate)	III (n) (skilled non-manual)	III (m) (skilled manual)	IV (partly skilled)	V (unskilled)
Current smoking levels						
Male	15	22	28	34	38	42
Female	14	21	29	28	36	37
Alcohol greater than 21 units—						
Male	28	35	32	30	31	29
14 units—						
Female	20	22	20	15	13	12
Overweight or obese						
Male	58	63	60	64	59	57
Female	45	51	49	56	57	60
Low physical activity						
Male	33	33	36	32	34	29
Female	37	40	41	42	43	40
Consumption of less than 5 portions of fruit and veg						
Male	64	71	79	80	78	83
Female	60	66	73	76	77	81

Source: Health Survey for England, 1998 and 2001.

Memorandum by Professor Sarah Cowley (HI 76)

THE CONTRIBUTION OF THE NHS TO REDUCING HEALTH INEQUALITIES

EXECUTIVE SUMMARY

1.1 The purpose of this evidence is to draw the attention of the committee to a small of piece of research that is just complete, but not yet published, which has relevance to the remit of this enquiry. This study is focused on the distribution and implementation of health visiting services in relation to area deprivation.

1.2 The major questions facing the committee are whether the NHS has a role in reducing health inequalities, given their social aetiology, and if so how. Although this study is focused on one occupational group and health need, it is argued that it provides valuable insight into the barriers faced within the NHS as a whole, in implementing its role in reducing health inequalities.

1.3 Evidence is provided showing that health visiting service provision is unrelated to areas of deprivation, although individual practitioners appear to focus efforts on the most deprived clients on their caseloads.

1.4 In conclusion, key areas of interest to this enquiry are highlighted, suggesting

- there is an absence of any NHS imperative to provide preventive or health promoting services
- there is a widespread and erroneous belief in the NHS, that curative, treatment services are a good substitute for skilled public health, preventive services.
- Joint targets do not automatically lead to consistency in service planning.
- Evidence of need and of suitable interventions for reducing inequalities are lacking across the NHS
- Measures of effectiveness in tackling inequalities are badly needed.

2. BACKGROUND

2.1 The purpose of this evidence is to draw the attention of the committee to a small of piece of research that is just complete, but not yet published, which has relevance to the remit of this enquiry. This study is focused on the distribution and implementation of health visiting services in relation to area deprivation.

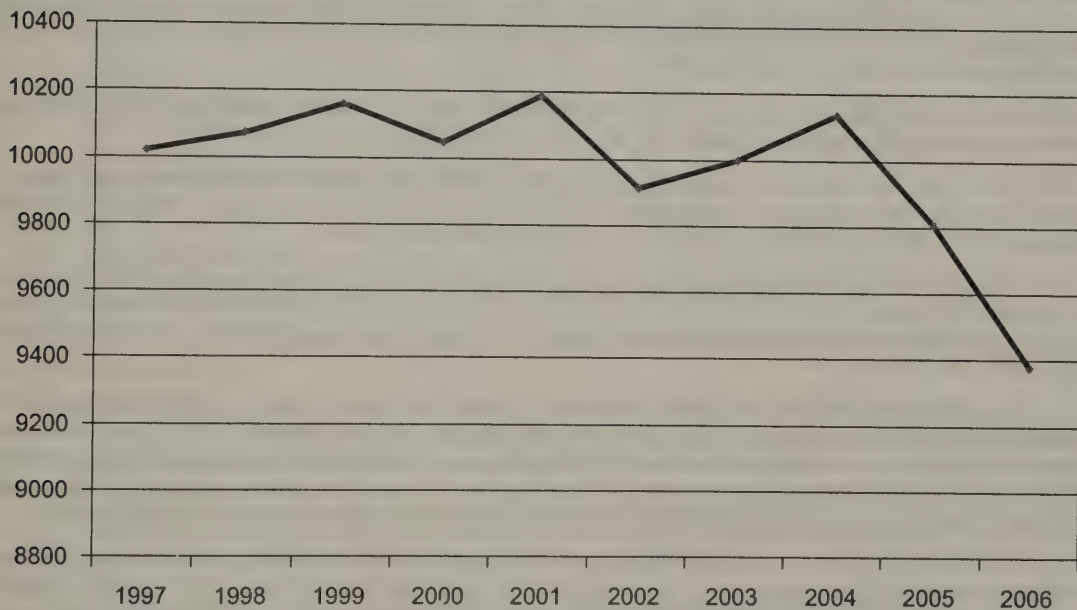
2.2 The major questions facing the committee are whether the NHS has a role in reducing health inequalities, given their social aetiology, and if so how. Although this study is focused on one occupational group and health need, it is argued that it provides valuable insight into the barriers faced within the NHS as a whole, in implementing its role in reducing health inequalities.

2.3 Evidence about the distribution, nature and causes of health inequalities far exceeds the amount of knowledge and information about what can be done to reduce them. However, there is national⁵⁸⁵, ⁵⁸⁶ and international⁵⁸⁷ agreement that the most effective actions include the provision of support to parents (particularly mothers) and young children.

2.4 Health visitors were the only occupational group named in Acheson's Independent Review of Inequalities in Health, with a recommendation that their role be strengthened. This has not happened; their numbers have fallen (see Figure 1). The latest published DH figures⁵⁸⁸ relate to September 2006; they show a dramatic fall in numbers of health visitors, and an ageing workforce.

2.5 This fall in numbers has inhibited health visitors' preventive remit, as shown in a national survey of their activities (see below)⁵⁸⁹, and a recent government review recommended limiting their remit to two focused roles⁵⁹⁰ instead of the former broad and inclusive remit.

Figure 1: Health visiting workforce 1997–2006



3. THE SURVEY

3.1 The D-SCOVOR (Determining future directions for health visiting: a Scoping Census Of health Visitor Registrants) survey of 15% of health visitors registered with the Nursing and Midwifery Council was undertaken in 2005, to establish baseline data about their current roles and activities. After one reminder, 1459 replies were received, representing a 46% response rate overall. This survey revealed two broad patterns of universal service provision to mothers with new babies; one comprehensive and one more restricted.

3.2 The comprehensive service pattern seemed to apply in around 40% of areas. This consisted of a package of antenatal and post-natal home visits (up to four in total) and of group and clinic based activities, such as post-natal support groups, baby massage and other community events to which new parents could be invited. Respondents indicated that this universal service should meet the needs of most new parents, but

⁵⁸⁵ Acheson D (Chair) Independent Inquiry into Inequalities in health. London, TSO, 1999.

⁵⁸⁶ DH Tackling Health Inequalities, A Programme for Action DH, London 2003.

⁵⁸⁷ Irwin L, Siddiqi A, Hertzman C (2007) Early child development: a powerful equalizer. Final Report for the World Health Organization's Commission on the Social Determinants of Health.
http://www.who.int/social_determinants/resources/ecd_kn_report_07_2007.pdf

⁵⁸⁸ DH workforce figures.

⁵⁸⁹ Cowley S, Caan, W, Dowling S, Weir, H (2007) What do health visitors do? A national survey of activities and service organisation. Public Health. doi:10.1016/j.puhe.2007.03.016.

⁵⁹⁰ Lowe R (Chair) Facing the Future: a review of the role of health visitors Department of Health, London. 2007.

if additional needs were identified, a range of services, including extra visits and specific group or community support activities, would be available. However, only 49% agreed that it was always feasible to deliver the core service.

3.3 The restricted service pattern, apparent in the remaining areas, revealed a core service consisting of only one visit, 10–14 days after the new birth was notified, baby clinics and child protection services. There were some groups and community services available in these places, but they were less prevalent than in the “comprehensive” areas. Overall, the absence of an antenatal visit predicted fewer postnatal visits; and fewer home visits predicted a smaller number of groups and community activities. In the opinion of 42%, it was not always feasible to deliver the core service, and most families would be unlikely to have their needs met by this restricted pattern of core services. Although additional services were said to be available once specific needs had been identified, it was not always feasible (30%) to deliver these services either.

3.4 Respondents provided postcode data for the services they described, and analysis showed some interesting correlations and contradictions, but limited details of how provision related to areas of deprivation or other services in an area. The Burdett Trust for Nursing funded a small extension study to examine these details, which is reported below.

4. RELATIONSHIP OF HEALTH VISITING SERVICES TO LEVELS OF DEPRIVATION OR AVAILABILITY OF OTHER SERVICES IN AN AREA

4.1 Background. Universal health visiting services are a primary line of defence against social exclusion, since they reach out to all families with new born babies, providing support for parents and for parenting at the most vulnerable and significant period of an infant’s life. There is increasingly strong evidence about the importance of the pre and post-natal period, and the early years, in determining future health, social well-being and educational achievement⁵⁹¹.

4.2 As well, there is strong evidence to suggest that health visitors’ preferred approaches of home visiting, community outreach and group support are very effective in reducing health inequalities^{592, 593, 594}.

4.3 Data from the Millenium Cohort Study showing that higher income families were more likely to contact health visitors were used to suggest that health visitors spend too much time with higher income families⁵⁹⁵ to be effective in their overall role in reducing health inequalities.

4.4 A counter-claim disputed that more time was, in fact, spent with such families, since so many contacts are initiated by health visitors rather than their clients. Also, better off families tend to have short queries that can answered in a single contact, whereas families with more entrenched problems need more time, or visits occur as a follow up⁵⁹⁶.

4.5 Data from the D-SCOVOR survey (described above), also suggest that it is unlikely that individual health visitors are spending most of their time with middle class families, since six out of ten of their most frequent activities are concerned with either child protection or social problems. However, the same survey revealed great inconsistencies in the level of health visiting service provision across the country. An analysis was undertaken across three sources of data to try and discern any rationale for these discrepancies.

4.6 Analysis at Primary Care Trust (PCT) level. Data gathered by the Family and Parenting Institute (FPI) were used (with their permission)⁵⁹⁷ to analyse the ratio of health visitors to children under five years, of age against the Index of Multiple Deprivation (IMD). IMDs are intended as a measure of deprivation within small areas, so caution must be exercised when using them to reflect larger geographical areas. Also, health visiting caseloads are usually organized around “natural areas” such as housing estates or GP catchment areas, rather than the Super Output Areas (SOAs) used for IMD scores.

4.7 The ratio of health visitors (full time equivalent) to children under five was calculated from data provided to the FPI under the Freedom of Information Act, and relates to staffing levels in December 2006. Whilst this provides an average “caseload” size for each full time equivalent (FTE) health visitor, specific team and corporate working arrangements vary from one PCT to another. There were missing data from six PCTs; two of those who supplied no information are in the most deprived quartile of areas. Figure 2 shows the rank of caseload sizes against the average IMD score for each PCT.

⁵⁹¹ Shonkoff J P, Phillips D A (Eds) *From Neurons to Neighbourhood: The Science of Early Childhood Development*. National Academy Press: Washington D.C. 2000.

⁵⁹² Elkan R, Robinson J, Williams D, Blair M. Universal vs. selective service. The case of the British health visitor. *Journal of Advanced Nursing* 2000, 33(1), 113–119.

⁵⁹³ Karoly L.A., Kilburn M. R, Cannon J.S (2005) *Early childhood interventions: Proven results, future promise*. Santa Monica CA, Rand Corporation, <http://www.rand.org/>

⁵⁹⁴ Macleod J & Nelson G. (2000) Programs for the promotion of family wellness and the prevention of child maltreatment: a meta-analytic review. *Child Abuse & Neglect*, 24, 9, 1127–1149.

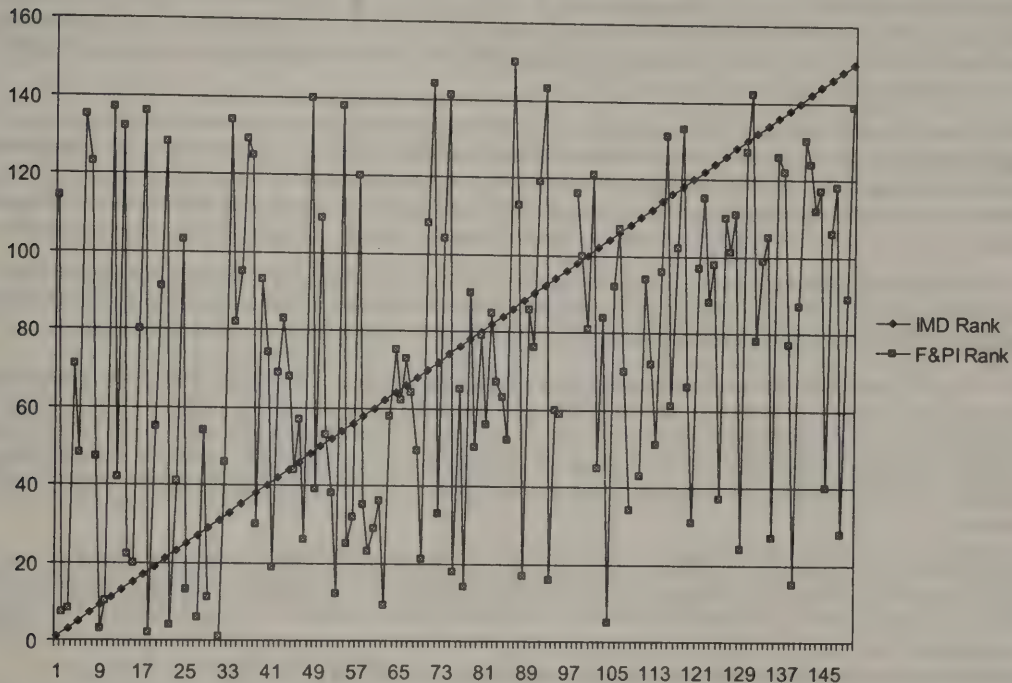
⁵⁹⁵ HM Government. *Reaching Out: an action plan on social exclusion*. Cabinet Office, Social Exclusion Task Force, London. 2006.

⁵⁹⁶ Anon. Class bias claim refuted. *Community Practitioner* Volume 80 Number 3 page 4.

⁵⁹⁷ Family and Parenting Institute (FPI). *Health Visitors: an endangered species* FPI, London 2007.

4.8 Primary Care Trusts (PCTs) were mapped to the IMD scores in 2004, but since then PCTs have been reconfigured, often merging into larger organizations, so further mapping was carried out to current (2007) configurations. The averaging process created some minor anomalies similar to that found in "rounding" of figures. Also, since PCTs extend across large population areas, most will encompass some areas of great deprivation and some areas of relative affluence. Detailed figures for the average score and "best fit" of both the IMD scores and ranks of PCTs are available on <http://www.kcl.ac.uk/schools/nursing/research/population/deprivation>.

Figure 2. Health visiting caseload size against IMD score



4.9 As shown in Figure 2, there is no apparent connection between distribution of health visiting services and levels of deprivation

4.9.1 Health visitors in 36 PCTs had full time equivalent caseloads of between 160.76 and 281.07 children under 5 years old; 14 of these PCTs fell in the most deprived quartile of areas, by IMD score (between 29.31 and 49.42) and rank (between 7 and 67)

4.9.2 Health visitors in 36 PCTs had full time equivalent caseloads of between 281.21 and 328.44 children under 5 years old; 10 of these PCTs fell in the most deprived quartile of areas, by IMD score (between 29.3 and 48.91) and rank (between 8 and 75.75)

4.9.3 Health visitors in 36 PCTs had full time equivalent caseloads of between 332.57 and 405.61 children under 5 years old; 8 of these PCTs fell in the most deprived quartile of areas, by IMD score (between 28.56 and 35.39) and rank (between 44 and 72)

4.9.4 Health visitors in 36 PCTs had full time equivalent caseloads of between 405.68 and 1,355.7 children under 5 years old; 10 of these PCTs fell in the most deprived quartile of areas, by IMD score (between 30.74 and 52.16) and rank (between 3 and 62.6).

4.10 There is a strong positive rank correlation (Spearman's $Rho = +0.807$, $p < 0.001$) between the number of health visitors and the number of children. The next strongest correlation between the local system measures and the IMD fields is weaker but telling: $Rho = +0.318$, $p < 0.001$ between PCT deprivation rank and the number of children under 5.

4.11 The PCTs ranked 1–30 (the 20% most deprived) have a mean of 15,089 children, and those ranked 121–150 (the 20% least deprived) have a mean of 26,166 children (t-test, $p < 0.001$). In other words, there are many more children living in areas that are not very deprived, with implications for the universal service. It would be expected that health visitors working in those areas would have less opportunity to meet many families in severe need. In turn, needy families living in such areas are harder to identify, except through a universal service.

4.12 The ratio of children to health visitors shows a smaller effect. The least deprived areas have slightly more health visitors per child than the most deprived areas, the difference being about 67 children per health visitor (327.7 vs. 394.4). This is significant at $p = 0.020$ (ie $p < 0.05$), but the ratio varies much less than the variations in numbers of children or in deprivation.

4.13 In their responses to the FPI, many PCTs rounded the number of children to the nearest 500 or even 1000, which tends to reduce the reliability of the calculations. Only the most significant items are reported above, because of the margin for error introduced by “rounding” of IMD scores and ranks in mapping from their original source to PCTs.

4.14 D-SCOVOR survey data were analysed with the associated IMD scores, but there seemed little logic behind the distributions at a strategic level.

4.15 In these data, health visitors in the most deprived areas spend most time with homeless people (rank correlation). They are also more likely to liaise with Sure Start (t-test with unequal variances, $p < 0.001$, mean difference in IMD 7.3). This would match expectations, because Sure Start Local Programmes (SSLPs) were first established in the most deprived areas, which is also where most homeless people are likely to be found. This points to some lasting benefit to the NHS role in reducing health inequalities, where SSLPs have been established and expanded their influence.

4.16 Those health visitors who liaise with Sure Start have significantly more frequent contact with pregnant teenagers and with pre-school Children (U-test, both $p < 0.001$). A small subset of the respondents ($n = 47$) had the most frequent contact (all the time) with pregnant teenagers: they worked in areas where the IMD scores are especially high (t-test for this small sample, unequal variances, $p = 0.009$: mean difference in deprivation score 6.8). This group included specialists focusing solely on that (young parents) population.

4.17 Health visitors in the most deprived areas also reported spending most time on administrative work (rank correlation). This is unsurprising given the additional documentation associated with child protection procedures and with referring clients to other services, such as social work or housing support.

4.18 Health visitors in the most deprived areas also make the fewest types of home visit, although not necessarily the fewest visits overall. D-SCOVOR only revealed data about the number of scheduled core services, not how faithfully they were carried out or how many additional visits were made. The extent to which the respondents felt their service was likely to meet most needs on their caseload was significantly correlated with the number of scheduled home visits (more likely to be “sufficient” if more visits are scheduled).

4.19 Neither the amount of group work nor the “core service” items were correlated at all with deprivation scores. Where an antenatal visit was offered by the service, significantly more postnatal visits were also scheduled (median values 1/4 three vs. two visits; Mann–Whitney U test, $P = 0.001$). The existence of a scheduled antenatal visit was, therefore, a marker for a more comprehensive core service, but this was not related to level of deprivation (t-test), nor was the presence or not of 1–5 post-natal visits.

4.20 In other words, service planning, set at PCT level, did not appear to take into account the need to schedule more visits or groups in deprived areas. Instead, assessments and planning of services would be entirely dependent upon the professional judgement and commitment of the health visitor.

4.21 Health visitors working in the most deprived areas appear to be focusing on those families who are most in need, sometimes because they are employed to provide a selective service targeting vulnerable groups. However, (bearing in mind limitations reported by respondents) once a need had been identified by the health visitor, it is quite likely that she would be unable to respond appropriately.

4.22 Finally a selection of Children’s and Young People’s Plans (CYPPs) was examined, to see if they provide any evidence at the planning level to explain the discrepancies and apparently ad hoc development of health visiting service levels and organization.

4.23 This review focused on the 10 PCTs with the best ratio of health visitors to pre-school children, then the 10 worst. A further 10 PCTs were systematically drawn from the list, choosing each 10th PCT. Local authorities are required to develop CYPPs, which are joint planning and commissioning documents; PCTs have a duty to co-operate in this exercise⁵⁹⁸.

4.24 The plans all reflected the framework provided, but varied in the amount of detail provided. All identified the areas that needed to be targeted as a result of deprivation, particularly where Sure Start Local Programmes were in place.

4.25 Although the needs were highlighted, specific details about how they were to be met were generally absent. Levels of co-operation between PCTs also appeared variable, reflected not only in the amount of detail about health-led services, but also in the absence of information about the impact that health services might have on later years.

4.26 In general, professionals and specific services were mentioned only in passing or as examples of how a strategic priority might be achieved. It was unsurprising, therefore, that health visitors and health visiting services were rarely mentioned, except to cite their universal availability. However, there was little to explain what that “universality” meant, exactly, in terms of service availability to parents and children.

⁵⁹⁸ HM Government. Joint planning and commissioning framework for children, young people and maternity services. London, Department for Education and Skills and Department of Health. 2006, www.everychildmatters.gov.uk/planningandcommissioning

4.27 More surprising, was the paucity of information relating to infants and pre-school children in general; they were barely mentioned beyond the provision of Sure Start Local Programmes and acknowledgement of the need for a "Foundation Stage Strategy." It would appear there is a need for commissioners developing these plans to be provided with a more in-depth insight into the importance (as outlined above) of early prevention and the impact of infancy and the pre-school years on the rest of a child's life and on later health inequalities.

5. CONCLUSIONS

5.1 Although this study is small and specific to a single occupational group (health visitors) and the population they serve (mainly families with pre-school children) it illustrates the way that specific barriers within the NHS operate to inhibit its role in reducing health inequalities.

5.2 There is strong guidance from government that health inequalities are a high priority for PCTs, very strong evidence that preventive services focused upon all mothers with young children is the best known approach to reducing health inequalities, and that health visitors are the best placed occupational group to deliver this form of support. Yet health visiting services are provided inconsistently, with patchy and underdeveloped services that are rapidly reducing, reflecting the absence of any NHS imperative to provide preventive or health promoting services.

5.3 Whilst noting the need to increase health visiting numbers⁵⁹⁹, the primary response from government to the reduction in health visiting numbers was to draw attention to the increase in other primary care nursing numbers⁶⁰⁰. This supports a widespread and erroneous belief in the NHS, that curative, treatment services are a good substitute for skilled public health, preventive services. If the NHS is to play any meaningful part in the reduction of health inequalities, this belief must be challenged.

5.4 Despite joint PSA targets, the policy requirement for PCTs and Local Authorities to collaborate in the provision of children's services appears inconsistent in the way it is being implemented. Educational authorities and early years services rarely include under-3s, and relevant outcomes are for local authorities, not the NHS. Joint targets do not automatically lead to consistency in service planning.

5.5 There appears to be a widespread lack of awareness of the crucial period of pre-natal to three years of age in reducing health inequalities, and of the evidence about how to influence this period. Evidence of need and of suitable interventions for reducing inequalities are lacking across the NHS, particularly in relation to children's services.

5.6 Measures of effectiveness in tackling inequalities are badly needed. Information for auditing the effectiveness of services affecting the health and life chances of children is in very short supply⁶⁰¹. A broad study conducted and implemented in Ireland provides helpful guidance and relevant indicators that might be adopted in the UK⁶⁰².

5.7 To offset the inconsistencies revealed in the small study reported here, some interim guidance has been developed and published about how best to commission generic health visiting services, which it is hoped might be supported by government. The principles might have wider currency in terms of guidance for preventive services^{603, 604}.

January 2008

Memorandum by the UKPHA (HI 77)

HEALTH INEQUALITIES

The UKPHA is an independent, UK-wide voluntary association, which through our membership brings together individuals and organisations from all sectors, who share a common commitment to promoting the public's health.

As a multidisciplinary organisation we seek to promote the development of healthy public policy at all levels of government and across all sectors. We act as an information platform and aim to support those working in public health both professionally and in a voluntary capacity.

⁵⁹⁹ Beasley C. A clear direction. *Community Practitioner* 2007. 80: 12, 3.

⁶⁰⁰ Department of Health (DH) The government response to Facing the Future: a review of the role of health visitors London, DH. 2007.

⁶⁰¹ Association of Public Health Observatories (APHO). Indications of Public Health in the English Regions, Report 5: Child Health. APHO, <http://www.apho.org.uk/apho/indications.htm> 2006.

⁶⁰² Brooks A-M & Hanafin S. Measuring Child Well-Being: An Inventory of Key Indicators, Domains and Indicator Selection Criteria to Support the Development of a National Set of Child Well-Being Indicators. The National Children's Office, Dublin, 2005.

http://www.nco.ie/viewdoc.aspx?fn=/documents/Publications/Well_Being_Indicators_Inventory_of_key_indicators.pdf

⁶⁰³ Cowley S. A funding model for health visiting Part 1: Baseline requirements. *Community Practitioner* 2007. 80: 11, 18-24.

⁶⁰⁴ Cowley S. A funding model for health visiting Part 2: Impact and implementation. *Community Practitioner* 2007. 80: 12, 24-31.

Our mission states that through our members, activities and co-operation with others, we aim to be a unifying and powerful voice for the public's health and wellbeing in the UK, focusing on the need to eliminate inequalities in health, promote sustainable development and combat anti-health forces.

UKPHA Priorities

Our three key priorities concerning public health are:

- Combating health inequalities—working for a fairer, more equitable and healthier society.
- Promoting sustainable development—ensuring healthy environments for future generations.
- Challenging anti-health forces—promoting health-sustaining production, consumption and employment; collaborating with businesses to promote socially responsible and healthy products and services.

UKPHA Definition of Public Health

At the UKPHA we believe that public health:

- is an approach that focuses on the health and well being of a society and the most effective means of protecting and improving it
- encompasses the science, art and politics of preventing illness and disease and promoting health and well being
- addresses the root causes of illness and disease, including the interacting social, environmental, biological and psychological dimensions, as well as the provision of effective health services
- addresses inequalities, injustices and denials of human rights, which frequently explain large variations in health locally, nationally and globally
- works effectively through partnerships that cut across professional and organisational boundaries and seeks to eliminate avoidable distinctions
- relies upon evidence, judgement and skills and promotes the participation of the populations who are themselves the subject of policy and action.

EXECUTIVE SUMMARY

From the above it can be seen that the UKPHA stance is that the NHS can make only a limited contribution to the reduction of health inequalities. However, a large proportion of our membership work within the NHS and strive to ensure that they tackle the social, environmental and economic determinants of health in their everyday practice. Their involvement in the UKPHA Special Interest Groups offers further opportunity to develop policy and practice in tackling health inequalities. This submission therefore has been developed in close consultation with our SIGs and we have included examples based upon the Pharmacy SIG and the Health Visiting SIG.(See below)

Our basic message is that the NHS has a significant role to play in reducing health inequalities but to do so to maximum effectiveness must:

- radically revise its culture,
- develop and value collaborative working relationships with communities, local authorities and other local agencies/organisations
- ensure that services at the frontline are adequately resourced and valued
- actively promote and sponsor research which identifies changes/innovations and interventions necessary to combat health inequalities

BRIEF INTRODUCTION

The NHS can and should contribute to a reduction in health inequalities as part of their core mission, but there are barriers (outlined below) to it performing this function.

Whilst the number of staff in the NHS has risen dramatically with the increased funding over the last 10 years, the number of public health staff and those concerned with prevention has fallen. This says something specific about the culture of the NHS, which is focused on treatment and cure, with a higher status afforded to those concerned with the “headline grabbing” interventions, such as those in intensive care, acute surgery and the working age population.

The NHS is heavily focused on illness and disease, and many would claim this as its proper function. However, the causes of health inequalities differ from the causes of disease. If the NHS only focuses on treatment, or even prevention of specific diseases, it will not succeed in reducing health inequalities

FACTUAL INFORMATION

There is a great deal of evidence about how health inequalities are manifest, but far less information about which interventions help to reduce them.

The Independent Review on Health Inequalities conducted by Sir Donald Acheson in 1999 identified that a focus on supporting mothers and babies/young children would be the best way to reduce health inequalities in the long. The only professional group named in that report was health visitors, as they had a track record of providing this form of support (see example below).

The structural, anti-health forces that contribute to health inequalities can only be changed in the long term (ie, over generations), leading to difficulties in identifying measures for progress so short term. This is not impossible, but would require investment in research of a different kind to that used to evidence disease-focused interventions.

We should differentiate upstream and downstream policy on tackling health inequalities. The NHS contribution tends to focus on downstream—because it is picking up the problems in physical illness and psychological distress which we might attribute to the structure of UK societies, socio economic issues.

BARRIERS

Failures in collaborative working

Although it is acknowledged that the NHS cannot, alone, reduce health inequalities. Its track record in collaborating with other agencies is not good, except where others are seen to relieve the burden from the NHS; eg, working with social services to reduce bed occupancy of older people.

The advent of children's centres, designed to improve collaboration for all working with the early years, has provided an opportunity. There are some very good examples of collaboration, with NHS, education and voluntary sector all working together, particularly where there were Sure Start Local Programmes. However, the majority are inadequately developed and focused on childcare and children over the age of 3 years, which both misses the most important period of development as far as health inequalities is concerned, and also fails to engage with NHS/health visiting services.

The excess winter mortality in the UK (25,000 extra deaths per annum) and unquantified excess morbidity amongst vulnerable groups, due to fuel poverty, could be dramatically reduced if frontline health care workers and other agencies involved with the delivery of energy efficiency and home heating improvements worked together, referring, sharing information and following through to ensure rapid and efficient remediation.

Similarly, more joined up working by the NHS with local authorities and the voluntary sector could make a significant reduction to the rising obesity levels which are strongly correlated with social disadvantage. Community involvement and participation, access to local fresh produce, the availability of green space, safe walking and cycling etc could all be enhanced if there were systematic working between NHS staff and their counterparts in local authorities and the voluntary sector.

Health Action Zones and Sure Start have both provided excellent examples of how to begin to engage communities and the evidence is beginning to come through to show early successes. Large changes in health inequalities cannot be seen in less than a generation. However, because they were both conceived as projects separate from the mainstream, they absorbed capacity and skills away from the NHS. Also, providing them with separate funding and management sent a message to the NHS that this was not their core business.

NHS Culture

NHS culture is focused on illness and disease is a barrier to reducing health inequalities:

- The efficient management of waiting lists and winter pressures etc is a testimony to the focusing and skill of NHS, but a different mindset is needed for the management and reduction of health inequalities.
- It is possible and likely that health inequalities will widen unless there is a parallel emphasis on prevention, which means enhancing access and expanding services to incorporate a community focus.
- The prevailing culture is one where mental health services are seen largely as the “poor relation”. Yet meaningful improvement in these services could significantly reduce the prison population and inequalities in employment opportunities, particularly for minority ethnic groups
- The achievements and incentives culture (QOF) is certainly not a true preventative model and will never help to address inequalities. Analysis shows that it is those GP practices in the more affluent areas which are reaching their targets.

Lack of evidence

The medical model of disease treatment informs views about what constitutes good research, and this can help with understanding some approaches to health inequalities. However, randomised controlled trials are not always feasible as a mechanism for showing how best to improve health inequalities, or how to organise services so they become more accessible to disadvantaged groups etc.

There is not only a shortage of research, but also a shortage of research funds available to focus on health inequalities. Tenders are generally assessed on how closely they conform to the medical ideal of the RCT

Lack of RCT evidence is cited as a reason for employing, or not employing particular approaches to reducing health inequalities

COMBATING HEALTH INEQUALITIES THROUGH THE NHS

Example 1: Health visiting services

The outcomes from health visiting are largely seen in areas other than the NHS, yet health visitors are employed/commissioned by the NHS. The need for their services is poorly recognised, because it is wholly focused on prevention, and the need for support of parents with young children is not often seen as a priority. In keeping with the NHS culture of prioritising the “acute” and “dramatic,” focusing on established problems, the “Nurse Family Partnership” approach is being rolled out to a small minority of disadvantaged families. Although this is a very positive programme for the few who receive it, it will reach far too few needy people to affect the statistics of health inequalities across the board. Also, since this appears to be being implemented at the expense of universal services for all parents with young children, it could potentially make inequalities worse.

Many health visitors and school nurses and their teams working in primary care/community services make an unseen and often unrecorded contribution to inequalities in health. They do this through the universal provision of services and by the advice and support they provide for families, signposting them on to other services, and agencies supporting them to seek help, with housing, education, child care employment etc.

Practice based commissioning tends to be very acute focused. The focus should be upon community or primary care based commissioning. Re-dressing this balance could help inequalities a great deal. Those nurses who are brave enough to run nurse led primary care services and employ their own GPs—not many as the hurdles are enormous—do help to reduce inequalities and they generally work in under doctored areas or with travellers and other disadvantaged groups

Example 2: Pharmaceutical services

There is a marked lack of information and research on pharmacy involvement in tackling health inequalities. However, the white paper *Choosing Health through Pharmacy* [DH 2005] suggests how the profession can help deliver the government’s public health agenda through a ten-year programme of engagement to 2015. It contains examples of good practice to encourage pharmacists to maximise their contribution to improving health and reducing health inequality. It has something to offer pharmacists in all NHS settings, covering community (high street chemists), hospital and primary care pharmacists. In addition, one of its main objectives is to send out a strong message to commissioners of health improvement services (who in the current structures are the real gatekeepers) and to the wider community of public health practitioners and specialists signalling that pharmacy is a willing partner in improving the public health.

The scarce evidence of pharmacy and public health

A review of the pharmacy practice literature and public health literature shows that community pharmacy has not traditionally been recognised as a key player in the public health movement. Although its core role originates in the safe preparation and dispensing of prescribed and over-the-counter medicines, in more recent times pharmacists have ventured beyond this to develop an “extended role”, contributing to health promotion and improvement through providing public information and advice at the community “high street chemist” base. Harding and Taylor (1994) reported that the profession has long struggled with the notion of public health whilst Jesson and Bissell (2006) assert that the profession had failed to grasp the full scope of the emphasis on a new public health agenda and its value base in tackling population health inequality.

More significantly, when Payne *et al* [2005] undertook a scoping exercise to measure pharmacy’s contribution to tackling health inequalities they observed,

“Most mainstream policy documents on health inequalities and social exclusion from the Department of Health pay little attention to the role of community pharmacies” and concluded “what this review highlights is that there is relatively little to date on the place of pharmacy in the drive to reduce health inequality—and that more should be done in this field” (p6).

In a context where there is little reliable evidence base for policy tackling health inequalities these resources confirm that there is scant evidence of the role of community pharmacy in the drive to reduce health inequalities.

It should be noted that Pharmacies and Pharmacists have made a considerable contribution to (downstream) public health lifestyle issues, where services can be combined with a product eg smoking cessation, EHC, diagnostic tests, minor ailments schemes. Such services have been linked with PCT through the new contract or Patient Group Directives (PGD). However, such services are not mainstream and when the funding is pulled the service ceases. So a lot of public health work was stopped when the NHS has funding crisis.

The multiples, Lloyds Pharmacy, Boots, Moss etc have seen a business opportunity to combine public health advice.. Lloydspharmacy was the first to advocate a social approach and has made more of providing a community based service (its shops are in disadvantaged areas especially West Midlands and moving into Wales). It is not clear what is going on in the Independent owned sector. However, none of this is mapped by deprivation index or population demographic data. It may well be that the multiples have such information but consider it to be competitive advantage data.

So we don't know to what extent these public health services reduce inequalities or increase them. There have been no research funds available to try and find out

RECOMMENDATIONS FOR ACTION

Our recommendations are self-evident from the above and we can only repeat what we stated in our summary:

To maximise its effectiveness in reducing health inequalities the NHS must:

1. radically revise its culture,
2. develop and value collaborative working relationships with communities, local authorities and other local agencies/organisations
3. ensure that services at the frontline are adequately resourced and valued
4. actively promote and sponsor research which identifies the changes/innovations and interventions effective and necessary to combat health inequalities

January 2008

Memorandum by the National Consumer Council and the National Social Marketing Centre (HI 78)

THE CONTRIBUTION OF THE NHS TO REDUCING HEALTH INEQUALITIES

INTRODUCTION

This paper is a response by the National Consumer Council (NCC) and National Social Marketing Centre (NSM Centre) to the Health Select Committee Health Inequalities Inquiry. The NSM Centre is based at the National Consumer Council and was established in 2006 to increase understanding and use of effective social marketing approaches at national and local level across the public sector and to work across sectors to build evidence based approaches to behavioral challenges. It is led by Director, Dr Jeff French and Deputy Director, Clive Blair-Stevens. The centre has a number of core staff and a wider number of social marketing associates that contribute to different areas and is assisted by input from the Department of Health and the National Consumer Council.

EXECUTIVE SUMMARY

We do not believe the government is likely to meet its targets on health inequalities without a significant re-focusing of effort, as set out in this submission. In particular, we would wish to emphasise:

- Action requires a systematic and sustained policy and delivery framework with adequate funding and clear role definition across the broader policy agenda [Q1]
- The development of insight based interventions, with clear behavioural goals, and a clear target population, needs to be incentivised [Q2,Q4], with a move away from the current block budgets funding mechanisms currently utilised
- There is a current skills and capacity deficit within the workforce, which needs to be addressed to ensure that interventions are developed which reflect customer understanding and systematic application of social marketing best practice [Q3]
- Investment is needed to build delivery partnerships, sharing user and customer intelligence, and building systems for capturing learning [Q5]

1. *The extent to which the NHS can contribute to reducing health inequalities, given that many of the causes of inequalities relate to other policy areas eg taxation, employment, housing, education and local government.*

1.1 Effective action on health inequalities requires a systematic and sustained policy and delivery framework with adequate funding and clear role definition across the broader policy agenda, recognising that a singular focus on the NHS will not tackle the broader determinants of health inequalities.

1.2 There is a need to distinguish between the Department of Health's role and that of the wider NHS. There are distinct contributions that the DH and the Wider NHS can make to tackling health inequalities but as yet this potential is largely untapped, or misdirected and of a wholly insufficient scale.

1.3 The DH and the NHS must also develop new skills in working with the private sector to address the issues of health inequalities.

The DH roles include:

1.4 Advocacy and leadership including through practical action in purchasing and contractual arrangements and in leveraging change across the broader policy and delivery environments. However this function it is not currently resourced to a level that it can have a significant impact across government and across the private and third sector.

1.5 Acting as a lead agency across government to begin a strategic dialogue leading to joint action between government departments and the private sector to tackle health inequalities.

1.6 Setting targets and the operating framework for the NHS. Action in these areas focuses attention on health inequalities, stimulating action and engaging support in sectors outside public health. Targets need to be more open and transparent, with greater clarity about who is being targeted. Recent policy has tended to target the manual occupation groups rather than the most deprived. This has widened the gap for health inequalities by exacerbating the absolute gap between the most deprived and the rest of the population.

The NHS roles:

1.7 Delivery within its own sphere of influence, to ensure its services are customer driven and informed by insight, with better segmentation of its audiences reflected in delivery of more tailored interventions across the life-course.

1.8 Greater investment is needed in developing skills within the NHS staff and the wider policy environment to engage with the broad social make up of disadvantaged populations, and to conduct research which can be translated into service provision which is both fit for purpose and welcomed by the target groups. This means the wholesale adoption of a systematic social marketing approach to understanding target audiences and developing services tailored to their needs.

1.9 Ensuring future service provision is informed by insight, with effective segmentation used to design, deliver and evaluate services. One of the possible consequences of this approach would be to restrict access to the service to the identified target group, thus reducing the potential for exacerbating the gap.

1.10 Moving away from short term and special project funding for community development programmes, health promotion programmes, working more closely with communities themselves to develop and deliver programmes which are locally appropriate and relevant with clear, measurable, short, medium and long term behavioural goals. However there is an absolute imperative to end poorly focused and poorly evaluated health promotion and community development interventions that have been the hall mark of much recent practice. The disciplines of a systematic social marketing approach need to be built into the inception and funding specifications of all future programmes if we are to attain the position of being able to more accurately assess the impact and return on investment of any future investment in tackling health inequalities.

1.11 Modeling and developing sustainable, insight informed, services. There is significant potential for re-orientation of existing services, for example community pharmacy, to include a broader outreach dimension to promote health in local communities. More effective cross organisational partnerships, such as that exemplified by the work between Knowsley PCT and Roy Castle's FagEnds, should be supported to develop and deliver effective, targeted, locally relevant services.

1.12 Mobilisation of wider partnerships and greater sharing of information and evaluation of what does and does not work to reduce health inequalities. The NHS could play a key leadership role in this process.

1.13 More targeted use of its huge organisational footprint. The NHS is the largest employer, the largest purchaser, the largest commissioner and provider of training in many areas. A strategy should be developed to harness this power to tackle one of the root issues of health inequality, meaningful employment and sense of self worth.

1.14 More support for community health action The NHS can and should as part of its core operating strategy aim to provide paid and volunteering opportunities on a much larger scale than hitherto.

2. The distribution and quality of GP services and their influence on health inequalities, including how the Quality and Outcomes Framework (QoF) and Practice-based Commissioning (PBC) might be used to improve the quality and distribution of GP services to reduce health inequalities.

2.1 Access to primary care can be a significant health inequalities issue. However, focusing solely on GP services may be counterproductive to the long term aim, with a wider conceptualisation of primary care services required to address health inequalities.

2.2 For some groups, especially marginalised groups, accident and emergency services are the point of entry into the health system. Rather than castigate these groups for inappropriate usage of services, there is a need to invest in research which considers why different groups see such services as their preferred point of entry, and look at how this can inform service design, commissioning and evaluation of service provision.

2.3 Existing data sources could be used more effectively to target health inequalities, through identification of people with known risk factors, ie smoking, for targeted interventions, eg smoking cessation services. This process could be incentivised through the QoF.

2.4 Research to date has identified that generic campaigns are less effective than interventions which are developed based on insight developed through research with defined target populations. Current funding structures, which generally favor short term projects deliverable within a financial year, militate against the development of such projects. Frameworks could be developed and used to incentivise more detailed scoping of projects, to address this shortfall.

2.5 Current DH programmes, which treat health inequalities as a cross cutting theme, have been effective in mainstreaming the recognition of health inequalities into all policy and programme areas, including the QoF and PBC frameworks. This approach should be extended across government to achieve maximum impact.

3. The effectiveness of public health services at reducing inequalities by targeting key causes such as smoking and obesity, including whether some public health interventions may lead to increases in health inequalities; and which interventions are most cost-effective;

3.1 Targeting key behavioural challenges, such as smoking and obesity, can be effective at reducing health inequalities. However, the evidence to date suggests that existing service models are potentially increasing the health inequalities gradient. This should not be regarded as a reason to forgo population based health reforms. Legislation and regulation, such as the smoke-free legislation, has had some impact, but needs to be seen as part of a spectrum of health promoting initiatives, not as an end goal.

3.2 There are strong links between motivation, environment, health behaviours and inequalities, with causal links between Health Behaviours (eg smoking & over consumption of food) coping mechanisms and deeply engrained Social Norms and Motivation.

3.3 Gaining deep insight and understanding into the consumer, their knowledge, attitudes and beliefs is essential to ensure that public health services are effective at reducing inequalities.

3.4 There is a need for a fundamental review of workforce and the skills that they will need to tackle health inequalities across all public sector organisations. We have in essence been fighting the new war with weapons developed to tackle the battles of long ago. The skill set and competencies needed for tackling behavioural, societal and managerial issues that sit at the heart of tackling health inequalities, whilst complementary to existing practice, are fundamentally different, and sustained effort is required to upskill and resource the workforce to reflect this

3.5 Many of the models of public health promotion used to date are best characterised as message and information driven campaign models. Whilst raising awareness is valuable, these campaigns are often not proving effective at motivating behavioural change. Good customer focused and researched social marketing is helping to break the default position of communicating messages to people as the primary way to influence behaviour. NHS London and SHAs in Yorkshire and Humber, The North East and The North West are all leading the implementation of social marketing principles in the development of future public health inequalities interventions. The work being carried out by these SHAs should be supported and spread to all NHS organisations.

Cost Effectiveness:

3.6 A recent study of the use of economic analysis in NHS decision making⁶⁰⁵ reports that respondents felt that economic evaluation was poorly understood and unrealistic in relation to NHS funding. These problems, compounded by the political and cross-sector nature of PHI, make it difficult to establish a clear process for taking decisions on public health investment. A review of public health decision making in eight countries⁶⁰⁶ concluded "none had explicit systematic procedures for making decisions affecting public health

⁶⁰⁵ Williams, J. Bryan, S. McIver, S. The use of economic evaluation in NHS Decision Making: A review and empirical investigation" August 2006 Health Economics Faculty University of Birmingham.

http://www.pcpoh.bham.ac.uk/publichealth/nccrm/PDFs%20and%20documents/Publications/Williams_et_al_Final_report.pdf

⁶⁰⁶ Allin, S. Mossialos, E. McKee, M. Holland, W. "Making decisions on public health: a review of eight countries" World Health Organisation Copenhagen 2004 www.euro.who.int/document/E84884.pdf

or setting priorities among different public health interventions". This report also notes that remarkable few public health interventions are subject to systematic evaluation, particularly in the field of primary prevention measures such as behaviour change.

3.7 There are two major challenges in the economic appraisal of Public Health Interventions; one is the difficulty of associating specific interventions with positive behavioural impacts and eventual health-related outcomes, and the second lies in the valuation of health-related outcomes. The latest and most comprehensive review of the evidence of the effectiveness of public health interventions in achieving behaviour change, by the NICE Behaviour Change Programme Development Group⁶⁰⁷ shows that while there are a great many studies in this field there are few that use consistent methods of analysis.

3.8 We would suggest there is a need for a systematic economic and evidence-based gap analysis to determine the most cost-effective funding level and intervention mix. Such a gap analysis should be used to develop decision tools for policy-makers and practitioners about how to best allocate resources to improve population health and tackle health inequalities. However, the development of decision aids will not produce foolproof algorithms that will remove the responsibility for judgment, but rather inform future decisions about investment and disinvestment.

3.9 The allocation of large block budgets in advance of the development of detailed social marketing plans is, in our view, a mistake. This approach to budgeting and resource allocation creates a culture of working to spend the budget allocated in the year it is allocated rather than the development of proposals to meet agreed targets and then costing these plans and seeking budgets to deliver them.

3.10 The current fixed-term block allocation system used by the DH to allocate funds to health promotion programmes and campaigns should be reviewed. There is a strong case for moving to a system of "mission-driven budgeting". Mission-driven budgeting, means only allocating budgets once a sound scoping phase and development phase of planning has been completed and convincing proposals have been developed that set out how budgets can be deployed to achieve desired outcomes.

4. Whether specific interventions designed to tackle health inequalities, such as Sure Start and Health Action Zones, have proved effective and cost-effective;

4.1 Evaluation carried out by Sure Start and Health Action Zones and the Cabinet office review of Area Based Initiatives demonstrates that the interventions, in their current form, have had at best a negligible impact on reducing health inequalities. In some cases it appears they have had a negative impact on reducing inequalities. The experience of the Spearhead Programme has yet to be assessed, but it seems unlikely that it will yield significantly different findings.

4.2 This depressing outcome reflects two specific deficits in the models used: the lack of specific, clear, actionable and measurable behavioural goals set by the projects at outset, and the failure to build the project based on informed insight, derived from scoping and qualitative research, into what would work with the target group. These failings would be addressed through the systematic application of social marketing principles and best practice.

4.3 Social marketing is at its core a systematic planning system driven by user or target group insight. Social marketing draws on commercial marketing techniques and principles as well as the social sciences and behavioural research to develop insight based interventions to promote positive behaviours. It is not just a health promotion strategy, as it can be applied to any behavioural challenge, nor is it a re-badging of old style campaign models of health promotion or health communication.

5. The success of NHS organisations at co-ordinating activities with other organisations, for example local authorities, education and housing providers, to tackle inequalities; and what incentives can be provided to ensure these organisations improve care.

5.1 Targets and the operating framework for the NHS have been crucial in focusing attention on health inequalities, stimulating action and engaging support in sectors outside public health. However, there is still a significant potential for mobilisation of wider partnerships, and greater sharing of information and evaluation of what does and does not work to reduce health inequalities.

5.2 Increasing co-terminosity of the NHS structures with local government is laudable. However, without effective sharing of best practice, information sharing, and the development of more collaborative working practices, at best this will have limited impact on the health inequalities gradient.

5.3 Investment is needed in building delivery partnerships, sharing user and customer intelligence and building systems for capturing learning across sectoral boundaries to tackle the underlying risk conditions faced by poorer people.

⁶⁰⁷ NICE Behaviour Change Group, "Behaviour Change, Synopsis of Evidence" December 2006 London <http://www.nice.org.uk/page.aspx?o=395480>

5.4 A key task as indicated above is to more meaningfully engage the private sector in tackling health inequalities. The Business in the Community model is a good example of a practice approach that could be extended. We would also recommend the use of the WHO developed health assets mapping methodology that seeks to identify and mobilise all the positive assets in communities from across the public private and third sectors to address community identified problems such as health inequalities.

5.5 Local Authorities and other public sector originations also have a huge role to play in using their organisational footprints to provide employment and training to those in most need. Local Authorities however like the NHS are not geared up to taking a segmented customer driven approach to tackling health inequalities.

6. *The effectiveness of the Department of Health in co-ordinating policy with other government departments, in order to meet its Public Service Agreement targets for reducing inequalities; and*

6.1 Across DH there are many examples of work which is being delivered successfully across government departments, eg health literacy. Such programmes can have a tangible impact on health inequalities.

6.2 We would strongly encourage the connection of health inequalities to wider agendas, both across government and within the field.

6.3 However, the translation of policy commitment into field ownership has not always been effective, reducing the impact of such policies.

6.4 The key issue is the scale of investment required to place health inequalities at the heart of delivery across government. The DH is well placed to lead this work but it needs to significantly up its game. The appointment of Dr Fiona Adshead as the new senior advisor for health inequalities and health determinants is to be welcomed as this would appear to signal the kind of step change in focus that is needed. The DH need to invest more and incentivise the NHS to invest more in taking on an active leadership role. We would suggest the establishment of a DH controlled but cross government funded innovations fund for health inequalities. Such a fund should be used to capture and spread good practice and build alliances nationally and locally across all sectors and agencies.

7. *Whether the Government is likely to meet its Public Service Agreement targets in respect of health inequalities.*

7.1 Evidence to date suggests that the ability of the health services to reach the most affected communities is inconsistent.

7.2 We believe that the government is unlikely to meet its targets without sustained effort and a re focusing of effort as set out in this submission.

January 2008

Memorandum by Whizz-Kidz (HI 79)

HEALTH INEQUALITIES

INTRODUCTION

Whizz-Kidz is the national charity and leading provider of wheelchairs and customised mobility equipment, wheelchair skills training, advice and support for disabled children and young people outside the NHS.

Whizz-Kidz is focused on addressing the unmet need among disabled children and young people for vital mobility equipment (including powered and lightweight manual wheelchairs) which they are not always able to access through the NHS statutory services⁶⁰⁸.

By providing an effective and timely health intervention, Whizz-Kidz addresses not only a disabled child's clinical and health needs—but also supports their development across the spectrum of outcomes that are envisaged by the "Every Child Matters" agenda⁶⁰⁹.

Providing the right wheelchair, early in life, is essential in order to satisfy basic human rights, and is the first step towards achieving independent living in the future⁶¹⁰. Independent mobility enables a disabled child to enjoy a full and active childhood. It helps to establish a more level playing field whereby young wheelchair users—who experience paucity of opportunity compared to their non-disabled friends—can actively take part, and develop the confidence and skills to participate fully in society.

⁶⁰⁸ *Don't Push Me Around! Disabled Children's Experiences of wheelchair services in the UK*, Whizz-Kidz and Barnardo's, 2006, http://www.whizz-kidz.org.uk/uploads/dont_push_me_around.pdf

⁶⁰⁹ Be healthy; Stay safe; Enjoy and achieve; Make a positive contribution; Achieve economic well-being. *Every Child Matters: Change for Children*, 2005

⁶¹⁰ "The right mobility equipment goes a long way towards realising the optimum growth and development of a disabled child, setting them on the right course in life." Professor Sir David Hall (President, Royal College Paediatrics 2000–2003)

Whizz-Kidz does not receive statutory funding and relies on voluntary funding to deliver its services. We work in partnership with the NHS on a case by case basis wherever possible, and in 2007, launched our first pilot initiative in partnership with Tower Hamlets PCT. Through the pilot we are working under one roof to systematically pool statutory and voluntary sector funding and expertise, to provide children with the right mobility equipment and training that meets their complete needs at school, at home, during play, in adolescence and through the transition to adulthood.

We actively targeting our resources to support deprived and hard to reach families, who are most at risk of poor health outcomes.

EXECUTIVE SUMMARY

1.1.1 As a third sector organisation which provides health services directly to disabled children and young people, our submission focuses on the health inequalities that are experienced by this demographic group.

1.1.2 We believe that the experiences of disabled children provide a particularly illuminating case in point. This is because of the entrenched nature of disadvantage experienced by this group—including poorer educational outcomes, inequality of opportunity, unequal access to health and social services, and an increased risk of poverty⁶¹¹.

1.1.3 All of these factors form part of the challenge in tackling health inequality. In the words of Rt Hon Ed Balls “if we can get it right for disabled children we can get it right for all children”⁶¹².

1.1.4 Despite the complexity, effective and timely health services, provided equitably to all those who require them, can help to reduce health inequality. Moreover early intervention in health can help to initiate an upward trend of more positive and equal outcomes in social and economic life.

1.1.5 We have drawn on the experiences of young people who have mobility impairments, and their ability to access effective wheelchair services to help illustrate these points and provide tangible examples. In doing so, we hope to identify common themes which are pertinent the broader debate.

HEALTH INEQUALITY: CHILDREN

1.1.6 The health services provided to children have been described as the “Cinderella Service” of the NHS, in which services have been planned and delivered according to providers’ convenience rather than on the basis of a child’s need⁶¹³.

1.1.7 This is despite evidence to show that early intervention can prevent health conditions from deteriorating and can improve life outcomes for children.

“the foundations of adult are laid in early childhood and before birth . . . slow growth and poor emotional support raise the lifetime risk of poor physical health and reduce physical, cognitive and emotional functioning in adulthood”⁶¹⁴

HEALTH INEQUALITY: DISABLED CHILDREN

1.1.8 Amongst those who are missing out on good health are disabled children. Aside from the existence of a health condition connected to a disability, disabled children have worse than average access to both general and specialist health services which puts them at greater risk of poor health outcomes⁶¹⁵.

1.1.9 The needs of families with a disabled child, which require input from professionals working across different agencies, are often unmet^{616, 617}. Families with disabled children experience a postcode lottery of provision⁶¹⁸. This is a mounting challenge for the health service as the number of children with complex and significant needs continues to grow⁶¹⁹.

1.1.10 A recent questionnaire sent to Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs) on behalf of the Department of Health found a variation from around 3 per cent to around 13 per cent in the proportion of total child health spend on disability services between different SHAs. The same survey found wide variations in the number of health services provided for disabled children (such as wheelchair services, speech therapy, or community equipment).

⁶¹¹ *Policy review of children and young people—A discussion paper*, HMT and DfES, January 2007, p57

⁶¹² Rt Hon Ed Balls MP, speech on childcare and child poverty, June 2007, http://www.hm-treasury.gov.uk/newsroom_and_speeches/speeches/econsecspeeches/speech_est_130607.cfm

⁶¹³ *Report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984–1995: learning from Bristol*. London: Stationery Office, 2001.

⁶¹⁴ *The solid facts* (second edition), Ed Wilkinson and Marmot, World Health Organization Europe, 2003

⁶¹⁵ HM Treasury, *Aiming High for Disabled Children; better support for families*, May 2007, pg 11

⁶¹⁶ Sloper and Bereford. *Families with disabled children*. BMJ, 2006.

⁶¹⁷ *Policy review of children and young people—A discussion paper*, HMT and DfES, January 2007, p63

⁶¹⁸ Prime Minister's Strategy Unit, *Improving the Life Chances of Disabled People* (Strategy Unit, 2004, pg114).

⁶¹⁹ Prime Minister's Strategy Unit, *Improving the Life Chances of Disabled People* (Strategy Unit, 2004, p35)

1.1.11 The DRC and Mencap have identified significant health inequalities experienced by people with learning difficulties, or mental health problems. Those most in need of health services may find themselves least likely to access the support they need.

The extent to which the NHS can contribute to reducing health inequalities, given that many of the causes of inequalities relate to other policy areas eg taxation, employment, housing, education and local government;

1.1.12 We support the point that health inequality is a multifaceted issue. Disabled children are more likely to have poorer outcomes across a range of indicators compared to their non-disabled peers, such as poorer access education and employment, increased risk of poverty, and lower access to health services resulting in poorer health outcomes⁶²⁰.

1.1.13 Because these factors are interconnected, it is important to provide health services that take into account the clinical, social and development needs of disabled children. This requires a multi-agency approach to planning, commissioning and assessment.

An example to illustrate this point

Over 70,000 children need a wheelchair to meet a clinical need, to satisfy their basic human rights, and to enable them to enjoy an active, independent childhood, just like their peers. Yet many thousands of families face waits of over a year to receive an appropriate wheelchair, or are simply unable to access the equipment they need through their local NHS Wheelchair Service⁶²¹.

Providing inappropriate mobility equipment can result in postural damage, the need for costly spinal surgery, and medication to relieve pain. Aside from the obvious detriment to a child's health, the failure to provide the correct mobility equipment, early in life (an example of an effective, health intervention) limits a disabled child's ability to take part in social and educational activities because they remain dependent on others. Boosting a child's life chances through provision of the right equipment can help mitigate the socio-economic factors which are part of the bigger picture of health inequality.

The distribution and quality of GP services and their influence on health inequalities, including how the Quality and Outcomes Framework and Practised based commissioning might be used to improve the quality and distribution of GP services to reduce health inequalities;

1.1.14 General health services could do more to support disabled children achieve better health outcomes by embracing the work underway (primarily through the "Aiming High for Disabled Children" agenda) to address the lack of data about the needs of disabled children. This could be achieved through the Quality and Outcomes Framework (a register of complex or specialist needs), or using existing mechanisms such as the Common Assessment Framework and Contact Point database.

1.1.15 In addition we would support data collection of unmet need, where families are unable to access the services they need through the statutory sector (for example because they have not met eligibility criteria) and have approached the third sector for support. This would underpin improved planning and commissioning of services in the future according to a genuine picture of local need, (rather than on the basis of what the state has historically been in a position to provide).

The effectiveness of public health services at reducing inequalities by targeting key causes such as smoking and obesity, including whether some public health interventions may lead to increases in health inequalities; and which interventions are most cost effective;

1.1.16 Research has demonstrated that disabled people are more at risk of obesity than non-disabled people. Providing the right opportunities for disabled children to be active and to take part in play activities has been identified as a key policy challenge⁶²². Additional steps must be taken to ensure that disabled children have the right equipment, support, and can access an environment in which they can play safely, and be active⁶²³.

⁶²⁰ HM Treasury, *Aiming High for Disabled Children; better support for families*, May 2007, pg 11.

⁶²¹ McColl 1986; Audit Commission, 2000, 2002, Prime Minister's Strategy Unit, 2005, HMT and DfES 2007, *Don't Push Me Around! Disabled Children's Experiences of wheelchair services in the UK*, Whizz-Kidz and Barnardo's, 2006, http://www.whizz-kidz.org.uk/uploads/dont_push_me_around.pdf

⁶²² DEMOS and Play England, *Seen and Heard: Reclaiming the public realm with children and young people*, November, 2007.

⁶²³ Key components—lightweight/sports mobility equipment, skills training, accessible play areas and recreational facilities, youth and sports clubs with trained staff.

Whether specific interventions designed to tackle health inequalities, such as Sure Start and Health Action Zones, have proved effective and cost effective;

1.1.17 Sure Start children's centres are valued by most of the families who use them⁶²⁴. However, more needs to be done to reach out and provide information and support (including accurate signposting and advocacy) to all those at greatest risk of poor health outcomes, including disabled children.

1.1.18 Research has shown that only five in 27 centres, demonstrated a close working relationship with their local primary care trust⁶²⁵. This must change if Sure Start can begin to provide support to families and respond effectively to local need.

The success of NHS organisations at co-ordinating activities with other organisations, for example local authorities, education and housing providers, to tackle inequalities; and what incentives can be done to ensure these organisations improve care;

1.1.19 Despite the focus on multi-agency working contained within the National Service Framework for Children, Young People and Maternity Services, LEAs, PCTs and Children's Trust need to work together more closely to provide services which meet the complete needs of disabled children. This must happen as the user level (multi-agency assessments of need) and at the service planning and commissioning level (to understand and address local need and make use of pooled budgets arrangements under the 1999 Health Act).

1.1.20 A practical example: providing a child with a powered wheelchair fitted with a riser, may be considered to satisfy an educational need. This is because it enables a child to attend a mainstream school, and take part in lessons and recreational activity with greater autonomy. It is rare for educational authorities to allocate funding to meet this need. At the same time, NHS wheelchair services may find that this kind of provision falls beyond the scope of their eligibility criteria because it is over and above a strictly "clinical" need. If a wheelchair is provided for use in school—it may be restricted and unavailable for use in other settings, even when this may be the preference of the child or parent.

1.1.21 It is hoped that the PSA target on Child Health and Wellbeing, and the 2008 NHS Operating Framework will help to mobilise local agencies to work together to improve services, and prioritise children's health services to a greater extent. The PSA includes an indicator which measures the experiences of families with disabled children across a range of services delivered by different providers. We hope this may prove effective in driving forward greater partnership working.

1.1.22 Establishing benchmark standards of care and measuring performance, sharing and rewarding examples of best practice, or innovative local solutions should also be used as drivers for change.

The effectiveness of the Department of Health in co-ordinating policy with other government departments, in order to meet its Public Service Agreements targets for reducing health inequalities;

Whether the government is likely to meet its Public Service Agreement targets in respect of health inequalities;

1.1.23 The cross-cutting nature of children's health inequality is reflected in cross-government PSA targets (also the child health and wellbeing PSA), and in the implementation of the Aiming High for Disabled Children programme which demarcates responsibility across the DoH and DCSF. It is important for the Department of Health to work even more closely with DCSF in order to progress the five Every Child Matters outcomes in full.

1.1.24 We welcome the fact that children's health services are a priority area for improvement in the 2008 NHS Operating Framework.

1.1.25 We support the introduction of a robust "core offer" which will outline the entitlement of families with a disabled child to a range of health, social and education services and will set their expectations with regard to transparency, participation, assessment and feedback. This has the potential to help reduce health inequalities among disabled children, in particular the requirement on local authorities to publish eligibility criteria, and drive up the quality of services.

1.1.26 Health inequalities can only be tackled by identifying and targeting resources towards those groups who are hardest to reach but at the same time most in need of support.

1.1.27 It is important to remain mindful of the fact that local decision making, although in principle more attuned to local need, can also entrench inequity as postcode practices persist. The onus will be on local agencies and third sector organisations working closely together to understand their population and to design services that reach target groups and enable them to lead healthier lives. At the same times vulnerable groups must be better supported to articulate their needs through better provision of information, and strong mechanisms for participation and feedback.

January 2008

⁶²⁴ National Audit Office, "Sure Start Children's Centres", 2006. http://www.nao.org.uk/publications/nao_reports/06-07/0607104.pdf

⁶²⁵ National Audit Office, "Sure Start Children's Centres", 2006. http://www.nao.org.uk/publications/nao_reports/06-07/0607104.pdf

Memorandum by the National Infertility Awareness Campaign (HI 80)

HEALTH INEQUALITIES

1. It was with great interest that I read the terms of reference of the Health Select Committee's inquiry into health inequalities and would like to take this opportunity on behalf of the National Infertility Awareness Campaign (NIAC)⁶²⁶ to respond to them.

2. I have focused comments specifically on the following aspect of the inquiry's terms of reference:

The extent to which the NHS can contribute to reducing health inequalities, given that many of the causes of inequalities relate to other policy areas, eg taxation, employment, housing, education and local government.

EXECUTIVE SUMMARY

3. Infertility remains a key example of health inequality in the NHS. Although positive steps have been taken to improve access to NHS funded infertility treatment, considerable variation continues to exist and patients' ability to access treatment often depends upon where they live.

KEY POINTS

4. NIAC is an umbrella organisation, established in 1993 with the support of a wide range of organisations involved in the field of infertility to campaign for fair and equal access to all those with an established clinical need to a full range of infertility treatment on the NHS.

5. Around one in six couples seek specialist treatment for fertility problems, and infertility can have a profoundly distressing and devastating impact. However, excellent results can be achieved in treating infertility if patients are rapidly investigated and referred for appropriate treatment. Unfortunately, patients have traditionally faced considerable inequality of access to treatment on the NHS, resulting in many having to resort to privately funded treatment.

6. NIAC therefore welcomed the publication in February 2004 of a clinical guideline by the National Institute for Health and Clinical Excellence (NICE), which aimed to address the inequalities in access to NHS funded treatment for infertility. At the time of its referral to NICE, the Government outlined its intention for the guideline to "help ensure that in future, infertile couples get fairer, faster access to clinically, cost effective and appropriate treatments"⁶²⁷.

7. Amongst other recommendations, the guideline stated that three full cycles of in vitro fertilisation (IVF) should be made available on the NHS to all those meeting agreed clinical criteria. Upon its publication, the then Secretary of State for Health, Rt. Hon Dr John Reid MP, asked Primary Care Trusts (PCTs) to make at least one full cycle of IVF available to all those eligible by April 2005, with the expectation of progress being made towards full implementation of the guideline in the longer term⁶²⁸.

8. Despite the publication of the guideline and the Government's announcement there continues to be considerable variation in provision of, and access to, treatment around the country. This is evident in terms of the number of cycles funded by PCTs, and whether those cycles include frozen embryo transfers (FET) as recommended by NICE. The large majority of PCTs still have not implemented the guideline's recommendation for three full cycles of IVF treatment. Some PCTs fund two cycles, most of them fund one and over the last couple of years, a number have suspended funding altogether.

9. There is also significant variation in the range of eligibility criteria used by PCTs for access to IVF treatment. For example, the female age range applied by PCTs can vary from the 23–39 years recommended by NICE to 34–39 years in some parts of the country. PCTs also vary in terms of whether previous treatment or previous children are considered an eligibility criterion for NHS funding⁶²⁹.

10. In Scotland, Wales and Northern Ireland, guidance on the provision of NHS funded infertility treatment was accompanied by centrally set eligibility criteria. NIAC welcomed these efforts to ensure that patients received equal access to treatment, regardless of where they lived. However, in England, PCTs are able to set their own eligibility criteria for access to NHS funding, over and above the clinical criteria recommended in the NICE guideline, which has perpetuated the inequality of access.

11. A likely move towards single embryo transfer (SET) as part of a national strategy recently announced by the Human Fertilisation and Embryology Authority (HFEA) to reduce the number of multiple births from IVF, has now made full implementation of the NICE guideline of even more importance, both in terms of funding three full cycles of IVF, and in ensuring that a full cycle includes the freezing and replacement of suitable embryos not replaced in a stimulated IVF cycle, as recommended by NICE.

⁶²⁶ <http://www.infertilitynetworkuk.com/InfertilityAwareness/?id=74>

⁶²⁷ Department of Health press release, *Working Towards Ending the Postcode Lottery of Infertility Treatment*, 30th November 2000.

⁶²⁸ Department of Health press release, *Health Secretary welcomes new fertility guidance*, 25th February 2004.

⁶²⁹ Department of Health publication, *Primary Care Trust survey of provision of IVF in England*, 2006, 23rd October 2007.

12. In October 2006, an independent expert group set up by the HFEA to look at reducing the number of multiple births from IVF recommended the introduction of SET for appropriate patients. NIAC supports this recommendation as a means of reducing the risks to the health and welfare of both mother and child that multiple births present. However, the group also concluded that failure to implement fully the NICE guideline, and the consequent lack and inconsistency of NHS funded IVF, was the single greatest obstacle to its introduction in the UK⁶³⁰.

13. Following the HFEA's public consultation on this issue, it called for multiple birth rates to be reduced to 10% following a 3-year national strategy. In announcing the development of the strategy, the interim Chair of the HFEA highlighted the need for PCTs to understand the connection between reducing multiple births and access to IVF when making funding decisions.⁶³¹ NIAC welcomed the HFEA's response as it is much more likely that patients will accept a move to SET if they have access to the three cycles of IVF, including FET, recommended by NICE. If a PCT is only funding one cycle, without FET, it is understandable that patients may be unwilling to accept a move that may reduce the chances of that one cycle being successful.

14. The Department of Health is currently funding a project with Infertility Network UK, a member of NIAC, to help improve access to infertility treatment by encouraging implementation of the NICE guideline. As part of this project, the Minister wrote to the NHS in July 2007 to clarify NICE's definition of a full cycle, which includes the freezing and replacement of suitable embryos not replaced in a stimulated IVF cycle.

15. In response to a survey carried out as the first stage of the project⁶³², which highlighted different interpretations of what constituted full implementation of the NICE guideline, the Minister also reminded PCTs of the recommendation for three full cycles of IVF to be made available and called for them to move towards providing this level. The letter also announced that the Department of Health would begin monitoring IVF provision across the country and that the project would be extended to include developing standardised eligibility criteria for PCTs to use⁶³³.

16. NIAC welcomes these steps and is keen to ensure that the tools developed from this project are used by PCTs to improve provision. It would particularly call for standardised eligibility criteria to be supported centrally to alleviate the current inequality of access. Further sustained action is also needed at both the national and local level to ensure real progress towards implementation of the guideline. NICE will be considering in early 2008 whether to review the guideline, yet it is still far from being implemented in full and patients still do not have equality of access to treatment across the country.

17. NIAC is grateful for the opportunity to respond to the Committee's inquiry and hopes that its comments will be taken into consideration.

January 2008

Memorandum by Help the Aged (HI 81)

HEALTH INEQUALITIES

Help the Aged wants a world where older people are free from the disadvantages of poverty, neglect and isolation, so they can live with dignity as valued, respected and involved members of society

1. INTRODUCTION

1.1 Help the Aged welcomes the opportunity to respond to the Health Select Committee's inquiry on health inequalities.

1.2 Help the Aged is a charity fighting to free disadvantaged older people in the UK and overseas from poverty, isolation and neglect. It campaigns to raise public awareness of the issues affecting older people and to bring about policy change. The Charity delivers a range of services: information and advice, home support and community living, including international development work. These are supported by its fundraising activities and paid for services. Help the Aged also funds vital research into the health issues and experiences of older people to improve the quality of later life.

1.3 In preparing this response, Help the Aged has drawn on our extensive research and experience of working with and talking to older people. Through the Charity's engagement strategy, Vocal Point, all issues older people raise with the Charity are logged and monitored to feed into the work of the organisation. We also proactively seek older people's opinions through focus groups and listening events, as well as liaising with members of Speaking Up For Our Age, a programme which facilitates and supports hundreds of local older people's forums.

⁶³⁰ One Child at a time, Report of the Expert Group on Multiple Births after IVF, 18th October 2006.

⁶³¹ Speech to the British Fertility Conference, 4th December 2007.

⁶³² Department of Health publication, *Primary Care Trust survey of provision of IVF in England*, 2006, 23rd October 2007.

⁶³³ NHS Infertility Treatment- Dear Colleague Letter, 31st July 2007.

1.4 Health inequalities amongst older people are a serious concern. The starkest demonstration of the gap between rich and poor can be seen in the gulf in life expectancy between different social groups. Despite the Government's commitment that no-one should be disadvantaged by where they live, the reality is that people who are poor, or who live in poor communities die earlier.

1.5 Health inequalities have wide ranging implications: Unless health inequalities can be addressed the raising of the State Pension Age between now and 2050 will have a disproportionate negative effect on people from lower socio economic groups. The pensions debate has focussed on the fact that, on average, the number of years people spend in retirement is increasing. However, the reality is that for some men in areas of Glasgow the average life expectancy is below the state pension age. This picture is replicated in other deprived areas of the country where many people will only live for a few years after they start receiving a pension, whilst in affluent areas people look forward to 30 years of retirement. Without action to tackle health inequalities the Government's entire ageing strategy will be in jeopardy.

1.6 Tackling health inequalities is not just a job for the Department of Health: The whole Government must continue to tackle poverty across all ages, and must work to support the development of communities which work for all their residents, in order to reduce the isolation and deprivation which leads to poor health.

1.7 Help the Aged understands that health inequalities are determined by a range of factors and this is reflected in our broad programme of policy work on issues that affect disadvantaged older people. This includes tackling fuel poverty, encouraging sustainable communities, combating social and financial exclusion, as well as promoting health and wellbeing.

1.8 Help the Aged is committed to supporting preventative health interventions. We are the leading voluntary sector agency in the field of falls prevention, linking with academics, clinicians and practitioners. We have a long-standing programme in this area which includes an annual Falls Awareness Day, resource production and commissioning original research. We supported Department of Health in the early development of the mid-life health check, and are linked in with its health trainer programme.

2. EVIDENCE

Poverty and health inequalities in the older population

2.1 In his analysis of the English Longitudinal Study of Ageing (Wave 2), Sir Michael Marmot demonstrates that income is a major factor in health deprivation and poor mobility for older people.⁶³⁴ More widely, ELSA documents how the risk of a wide range of conditions such as cardiovascular disease, arthritis, respiratory and psychological illness increases not only with age but also for manual workers (and retired manual workers), for those living in the North East and North West of England and for those with the lowest income.⁶³⁵ There are significantly higher rates of early deaths from cancer, circulatory disease and smoking-related deaths in the north of England.⁶³⁶

Life expectancy

2.2 Life expectancies, both at birth and at age 65, also show a large gap between the richest and the poorest parts of the country—someone aged 65 living in Kensington and Chelsea can expect to live on average 8 years longer than a 65-year-old in Glasgow City.⁶³⁷

2.3 On average, men in the UK can expect to live their last 6.9 years with a disability. For women, the figure is 8.7 years.⁶³⁸ Healthy life expectancy is shorter for those in lower socio-economic groups, both in Great Britain and most of the rest of the EU.⁶³⁹

Future health projections

2.4 In the next ten years in the UK, it is estimated that there will be⁶⁴⁰:

- Nearly seven million older people who cannot walk up one flight of stairs without resting
- One-and-a-half million older people who cannot see well enough to recognise a friend across a road
- Over a third of a million with major speech problems

⁶³⁴ Presentation by Sir Michael Marmot at the launch of ELSA wave 2 Equalities Review Seminar "Older People and Inequality", 2006.

⁶³⁵ English Longitudinal Study of Ageing, Wave 2, 2006.

⁶³⁶ Health Profile of England 2007.

⁶³⁷ "Inequalities in life expectancy at 65", Office for National Statistics, 2007.

⁶³⁸ Estimate based on Disability Free Life Expectancy for 2004 from Health Statistics Quarterly 33, Spring 2007, ONS and Period Life Expectancy for 2004, Government Actuary Department website.

⁶³⁹ Health Inequalities: Europe in Profile, European Union 2005.

⁶⁴⁰ Help the Aged estimate from Health Survey for England 2005, Research into Ageing factsheets, Dementia UK (Alzheimer's Society et al) 2007, SENSE factsheet 11, Wanless Review 2006 and Survey of English Housing 2006, calculated for the UK on a projected 24.5% rise in the 65+ population by 2017.

- Over 4 million with major hearing problems
- Up to a third of a million people aged 75+ with dual sensory loss
- Over a million people aged 75+ who find it very difficult to get to their local hospital
- A third of a million who have difficulty bathing
- Nearly a million with dementia
- Between 4–7 million with urinary incontinence
- One-and-a-half million suffering from depression
- Five per cent of men and six percent of women with three or more of the functional limitations listed above

2.5 These statistics demonstrate the importance of reaching the older population with public health initiatives. To do this, we believe it is vital that targeted initiatives are developed. Whilst we are supportive of a broad public health agenda, we believe that, in designing and implementing public health programmes, we must differentiate between the needs of different populations. The needs of older people, and the ways in which they can be engaged with public health initiatives, will differ from other populations such as children and families.

2.6 Below we offer some comments on the Committee's specific areas of inquiry.

3. *The extent to which the NHS can contribute to reducing health inequalities, given that many of the causes of inequalities relate to other policy areas eg taxation, employment, housing, education and local government*

3.1 The NHS has a key contribution to make to the work to address health inequalities faced by older people.

3.2 Whilst it is true that health inequalities persist amongst groups who are in poverty, or who live in poor communities, too often it is the failure of the NHS to adequately fulfil their obligations to these communities which is the problem—not their poverty in itself.

3.3 A key example of this can be seen in the area of foot care. The failure of NHS trusts to prioritise foot care has resulted in a severe lack of podiatrists at the local level to meet the needs of older people⁶⁴¹. A study for Help the Aged estimated that 25% of people over the age of 65 who need professional foot care were not receiving it and that to provide this level of services would require nearly doubling the size of the podiatry service. Clearly those worst affected are those on the lowest income, with the poorest health outcomes, because they cannot afford to buy podiatry services privately. The implications of untreated foot problems are serious. Older people suffering from foot problems are likely to suffer unnecessary pain, are less likely to be physically active and are at greater risk of falls. In this way gaps in NHS provision have a direct impact on health inequalities.

3.4 Similarly the patchy provision of quality continence care contributes to unequal health outcomes. Help the Aged's research⁶⁴² suggests that incontinence has the potential to contribute to social isolation. Incontinence is not an inevitable part of ageing but the condition is more common in older age. 15% of older men and women over 65 living at home have faecal incontinence. The condition is not well assessed and treated: many people report they have been given a pad to stop leakage and full assessments are not made. A recent continence audit found services across the country were patchy and many continence adviser posts and budgets for incontinence products are subject to cuts. The NHS could play a key role in tackling incontinence earlier and more effectively, and thereby address a much broader range of issues in older people's health.

3.5 The NHS can also play a vital role in ensuring more people understand how to look after their own health, for example through the promotion of the physical exercise—ensuring that the gym is not seen as the preserve of the middle classes. Rates of physical activity decline with age, as identified in the recent Sport England survey⁶⁴³, but international evidence suggests that this is not inevitable. We believe the NHS could do more to encourage physical activity as a way of preventing ill health, promoting good health and maintaining independence. Although not exclusively a health issue, as barriers to participation may be the result of poor provision locally, lack of transport links, perceived risk of crime, nevertheless the NHS has an important public health role in working with local authorities to promote the benefits of and opportunities for getting active. Some communities have successfully piloted the idea of "exercise on prescription" but this is not universally available, and inevitably it tends to be those who are more articulate and assertive, in more affluent communities who are better able to access these options (the inverse care law).

3.6 In sum, whilst it is important not to over-estimate the role of the NHS in tackling health inequalities, if the NHS focussed more attention on those medical conditions which impact older people's broader quality of life, it is likely there would be a real impact on health inequalities.

3.7 Ultimately, however, a multi-pronged strategy will be needed to tackle health inequalities.

⁶⁴¹ Best Foot Forward, 2005 (Help the Aged).

⁶⁴² Incontinence and older people: is there a link to social isolation (<http://policy.helptheaged.org.uk/healthyageing>).

⁶⁴³ Active People Survey results, 2006 (Sport England).

3.8 Poverty is clearly a central consideration. It remains the case that those who are wealthier can afford to stay active and healthy, those in poverty cannot. This is not just about the ability to buy into private solutions to health problems, where the NHS fails, but also about the wider impact of a life in poverty. The 2 million older people living in poverty in the UK often face harsh choices when budgeting on very low incomes. Research carried out by Help the Aged has shown that people are unlikely to go into debt or arrears with bills but instead cut back on basics such as fuel and heating. This can have serious implications for health, especially in winter where not heating the home properly can put people at increased risk of death from cold related illnesses. In addition, poverty can be extremely isolating as people cannot afford to be involved in leisure activities, due to the cost of the activity or itself or due to the cost of transport (a particular issue for those with mobility impairment or disabilities who cannot use buses and therefore do not benefit from a free pass.) In addition, communities which are lacking in facilities and services also exacerbate isolation.

3.9 In a Help the Aged survey of older people's views on public toilet provision in their local area⁶⁴⁴ 52% of respondents agreed that the lack of public toilets in their area stopped them going out as often as they would like. Large numbers of people who are tethered by an invisible "bladder leash" which restricts their movements to within easy reach of toilets, thus contributing to social isolation and the resulting health impacts.

3.10 A further Help the Aged survey⁶⁴⁵ suggested that 2.5 million older people have fallen on pavements and 13% of those people reported that the episode had left them afraid to leave home.

3.11 All too often, poorly served communities are poorer communities—leading to a cycle of disadvantage and poor health.

3.12 Another key issue is access to skills training and learning opportunities. Learning activity not only brings benefits in itself, through helping to keep the mind active, but can also give people the knowledge and tools they need to maintain healthy lives. Unfortunately recent cuts in adult education budgets have led to concessionary rates for older learners being withdrawn—as a result adult education now remains the preserve of the more affluent older person.

4. The distribution and quality of GP services and their influence on health inequalities, including how the Quality and Outcomes Framework and Practice-based Commissioning might be used to improve the quality and distribution of GP services to reduce health inequalities

4.1 It is important that GPs are accessible to older people and physical access is therefore a key consideration. However geographical location need not be a major concern if appropriate transport is made available. All too often, though, older people find it difficult to make appointments to correspond with off-peak periods when bus passes can be used. But accessibility means more than just location, and ensuring a GP is approachable and helpful is also important. Older men's reluctance to approach GPs is well documented and therefore outreach programmes will be needed to reach some of those most at risk. There can also be issues for some older people, with the length of time allocated for GP appointments—which may not be sufficient for them to feel they can discuss their health concerns in full.

4.2 There are particular concerns around access to primary care for people in care homes. Many older people are deregistered by their GP when they go into a home, and allocated to the home's chosen GP. Some homes struggle to secure GP services, with some doctors asking for retainers to work in care homes. Help the Aged has investigated this issue as part of My Home Life programme (www.myhomelife.org.uk).

4.3 Other older people fall victim to age discrimination in health care. Help the Aged recently supported 500 older people to respond to the Government's consultation on discrimination law. Many responded with personal stories of age discrimination at the hands of medical professionals.

4.4 One woman reported:

"My mother saw her GP for years complaining of back pain. He never examined her and told her it was old age. When she moved . . . the new GP sent her for a scan and found she had a tumor the size of a football in her back"⁶⁴⁶

4.5 Help the Aged believes the Quality and Outcomes Framework could be used to improve older people's access to key health interventions—particularly in the area of falls and bone health. Osteoporosis is a serious problem amongst older people, and has an enormous impact on quality of life, yet access to bone density screening remains patchy.

4.6 Falls represent the most frequent and serious type of accident in the over-65s and are a serious cause of morbidity and mortality. 30% of community dwelling people over 65 and 50% of those over 80 years will fall in 12 months with 60% of those who fall once, falling again within the same year. A proportion of these will fracture. Half of those who suffer a hip fracture never regain their former level of function.

⁶⁴⁴ Nowhere to go: public toilet provision in the UK, 2007 (Help the Aged).

⁶⁴⁵ Spotlight report, 2007 (Help the Aged).

⁶⁴⁶ Less Equal than Others: Older People's Responses to the Discrimination Law Review, Help the Aged 2007.

4.7 The recent Royal College of Physicians clinical audit of falls services found that quality was inconsistent across the country and bone health services lagged behind in many areas. Inequality of access to assessment and high quality treatment may contribute to inequalities in health outcomes.

4.8 Involving GPs in the identification and treatment of those at risk of falls and with poor bone health would be a key way of tackling this issue, but unless falls and bone health are included within the QOF it is unlikely that progress will be made. Unfortunately, the ongoing debate over the new GP contract, which many organisations including Help the Aged argued should include falls and osteoporosis assessment and treatment, has reached an impasse.

4.9 In terms of the role of Practice Based Commissioning, it is not clear whether, at the moment, GPs have the information they need to effectively target health inequalities affecting their localities, nor is it clear they have the expertise required to determine how to address them. If GPs are to undertake this role at all effectively they will certainly need to engage with the local Strategic Needs Assessment, undertaken by the PCT and local authority.

5. The effectiveness of public health services at reducing inequalities by targeting key causes such as smoking and obesity, including whether some public health interventions may lead to increases in health inequalities; and which interventions are most cost-effective

5.1 Clearly smoking and obesity are serious health concerns and need to be tackled as part of the onslaught on health inequalities. However too often the marketing of initiatives in these areas does not reach out specifically to older people, and as a result older people fail to benefit. Furthermore, Help the Aged is concerned that the heavy emphasis on these high profile issues may lead to the neglect of the particular issues faced by older people.

5.2 It is right that the current obesity epidemic is a focus of Government thinking; however the coverage of this matter can crowd the public health space, so that the complex nutritional needs of vulnerable older people are not addressed. Many vulnerable older people need support with healthy eating, but may not be reached by broad brush messages around obesity. Indeed recent studies have highlighted the vulnerability of older people to malnutrition (particularly those in care settings). It is vital that this problem is identified and addressed, through both targeted public health messages to older people about eating well, and support from healthcare professionals such as nutritionists.

5.3 Similarly, generalised messages and initiatives about increasing levels of physical activity are unlikely to reach older people. Targeted programmes will be needed to ensure older people are not excluded from the opportunity to maintain their health through physical exercise.

5.4 Help the Aged's experience of running falls prevention initiatives demonstrates the importance of ensuring careful targeting of initiatives designed to improve health. In response to concerns about the failure of some BME groups to access mainstream falls prevention provision, Help the Aged established a Minority Ethnic Elders Falls Prevention Programme. The scheme piloted exercise classes and other initiatives aimed at minority communities within certain localities. The pilots demonstrated the importance of taking into account factors such as language, culture, and requirements around time of day, food etc, in order to ensure the needs of all communities are met.

6. Whether specific interventions designed to tackle health inequalities, such as Sure Start and Health Action Zones, have proved effective and cost-effective

6.1 Help the Aged does not have specific experience of Sure Start or Health Action Zones.

6.2 However, anecdotal evidence from public health professionals at the local level suggests that initiatives such as health trainers have been extremely helpful in improving the outreach of PCTs to disadvantaged sections of the community. Evidence of impact on health outcomes is much more difficult to obtain. Further anecdotal evidence, however, suggests that older people have been responsive to targeted interventions and support from health trainers, for example a health trainer in one local area supported walking groups amongst older people to promote health, by going into a care home to explain benefits of physical activity, and how activity can be taken in small chunks.

6.3 It is essential that health trainers reach out to older people in their local community and where possible, older people are recruited as health trainers themselves.

6.4 We have also been impressed by the work undertaken as part of the Partnerships for Older People Projects (POPPs) pilots, and the Link Age Plus pilots, both of which have focussed on early intervention to reach disadvantaged older people and improve health and well-being outcomes. Initiatives undertaken as part of these schemes have included promoting physical activity, smoking cessation and access to nutrition information and advice. It is important to note that both these schemes specifically target older people through outreach in the community. Both projects are ongoing, so evaluations are not yet complete, however we believe it is likely that evaluation will show the importance of targeting and outreach in accessing the most disadvantaged older people.

7. The success of NHS organisations at co-ordinating activities with other organisations, for example local authorities, education and housing providers, to tackle inequalities; and what incentives can be provided to ensure these organisations improve care

7.1 As discussed above, health inequalities amongst older people are the result of multiple factors. Multi-pronged approaches will be vital if we are to tackle health inequalities and reduce morbidity and mortality amongst older people. Unfortunately, we know that joining-up has proved a challenge in public health initiatives.

7.2 However, there have been some successes at the local level, particularly where partnerships have been brought together through initiatives such as POPPs and Link Age Plus (as described above).

7.3 Unfortunately budgetary pressures on the part of all agencies tend to militate against joint working outside pilot areas. The new framework of Public Service Agreements, indicators and Local Area Agreements may prove more conducive to budget pooling and joint activity to tackle health inequalities—but this remains to be seen.

8. The effectiveness of the Department of Health in co-ordinating policy with other government departments, in order to meet its Public Service Agreement targets for reducing inequalities

8.1 The Department of Health continues to face challenges in securing cross-Governmental buy-in to reducing health inequalities.

8.2 Cold-related mortality remains a serious problem in the UK with the level of excess winter deaths amongst older people averaging around 20,000 per year. Whilst these deaths are attributable to multiple health conditions, many of which could be impacted by health interventions, there are also links to fuel poverty, non-decent homes and lack of income. However, so far the Government has struggled to take a fully joined up approach to tackling this problem. Department of Health initiatives have focused on advice to older people, whilst DWP initiatives have focussed on the provision of benefits such as the winter fuel payment, Defra has provided Warm Front to try to improve heating and insulation in homes, and the DCLG has sought to tackle inadequate housing through the Decent Homes initiative. Whilst there are many departments involved in activity which might impact the problem of cold-related death, we struggle to describe this as a truly joined up initiative, as coordination across these initiatives is limited and each department chalks up its contribution in relation to its own internal objectives, rather than any broader Governmental aspiration.

8.3 In some localities, enthusiastic and committed individuals have brought together initiatives on winter cold with positive results, but this has not been replicated nationally.

8.4 The new framework of Public Service Agreements, and particularly PSA 17 which makes improving older people's well-being a cross Governmental aim, may herald a new dawn in joining up across Government, but as noted above this remains to be seen.

9. Whether the Government is likely to meet its Public Service Agreement targets in respect of health inequalities.

9.1 Clearly if the Government does not reach the over 50s with its public health messages and initiatives it will fail to reach its targets. At present, however, public health work tends to exclude older people because of its generalised nature.

9.2 As we have argued above, whilst a broader public health approach is laudable, reaching older people (and particularly more disadvantaged and excluded older people) requires specific targeted initiatives.

January 2008

Memorandum by the Sickle Cell and Young Stroke Survivors (SCYSS) (HI 82)

HEALTH INEQUALITIES

EXECUTIVE SUMMARY

Sickle Cell disease is currently the number one inherited severe genetic disorder in the United Kingdom. It affects mainly people of African and Caribbean origin and is the commonest cause of stroke in childhood. Sufferers who are persistent users of hospitals and the NHS suffer everyday as a result of the vast inequalities within the health system and we are glad to have the opportunity to make a contribution to the work of the select committee and urge the committee to view the case of sickle cell and stroke as one that demonstrates the vast amount of work that needs to be done to redress inequalities as this condition has vast implication across, child poverty, health, education, social care, housing and disability access amongst other things that are currently not being addressed.

By not ensuring the provision of optimum care and treatment for children with conditions such as sickle cell that overwhelmingly affect minority communities, the Department of Health is inadvertently penalising ethnic groups which already suffer serious health disadvantages. As such SCYSS believes this matter is extremely pertinent to the government's commitment to reducing health inequalities.

SCYSS therefore recommends that the Health Select Committee consider how conditions such as sickle cell affect the health outcomes of certain ethnic groups during its inquiry. The Committee should consider how the Department of Health could reduce health inequalities caused by sickle cell disease by enforcing national guidelines.⁶⁴⁷

INTRODUCTION

Sickle Cell and Young Stroke Survivors (SCYSS) was set up in June 2005 by a parent of a sickle cell stroke survivor. She was appalled by the treatment that her son received and the lack of coordination between a wide range of services who failed to take responsibility to provide streamlined care and support. The organisation now has registered charity status.

The charity provides advice, support and advocacy for children, young people and their families that are affected by sickle cell disease and Stroke.

Sickle Cell disease is a genetic condition that affects mainly people of African and Caribbean origin. It causes the red blood cells to be starved of oxygen causing them to become sickle shaped. This can result in blockage in blood vessels which can cause severe pain, damage to vital organs including the brain resulting in strokes and possible death.

HEALTH INEQUALITY

SCYSS welcomes the Select Committee's inquiry into health inequalities and is pleased to submit evidence to the Committee.

Sickle Cell is a condition that affects people of African and Caribbean origin. As Sickle Cell is the commonest cause of stroke in childhood, children of these ethnicities are at greater risk of stroke than other groups.

By not ensuring the provision of optimum care and treatment for children with conditions such as sickle cell that overwhelmingly affect minority communities, the Department of Health is inadvertently penalising ethnic groups which already suffer serious health disadvantages. As such SCYSS believes this matter is extremely pertinent to the government's commitment to reduce health inequalities.

SCYSS therefore recommends that the Health Select Committee consider how conditions such as sickle cell affect the health outcomes of certain ethnic groups during its inquiry. The Committee should consider how the Department of Health could reduce health inequalities caused by sickle cell disease by enforcing national guidelines.⁶⁴⁸

Responding to the specific terms of reference in the inquiry, SCYSS has the following comments:

The extent to which the NHS can contribute to reducing health inequalities, given that many of the causes of inequalities relate to other policy areas eg taxation, employment, housing, education and local government;

While recognising that health inequalities have many causes, the NHS has a large contribution to make in reducing health inequalities. The NHS needs to respond to the needs of the local population in order to contribute to the reduction of Health Inequalities. This includes responding to the particular needs of ethnic minorities, such as those people of African and Caribbean origin who have sickle cell disease, to reduce health inequalities based on ethnicity.

SCYSS is aware of many examples related to sickle cell where the NHS has not responded to the needs of this group of patients. Some examples include lack of provision of treatments and care for sickle cell patients including:

- TCD scanning for the prevention of stroke
- Funding battles for oral iron chelation which is vital to prevent instant death by heart attack in young sickle cell stroke victims
- Lack of coordinated follow up treatment for young stroke survivors
- Lack of availability of MRI scans within 48 hours of a child being diagnosed with a stroke.

⁶⁴⁷ NHS Antenatal and Newborn Screening Programmes "Sickle Cell Disease in Childhood: Standards and Guidelines for Clinical Care" October 2006 and Royal College of Physicians Paediatric Stroke Working Group "Stroke in Childhood: Clinical guidelines for diagnosis, management and rehabilitation" 2004.

⁶⁴⁸ NHS Antenatal and Newborn Screening Programmes "Sickle Cell Disease in Childhood: Standards and Guidelines for Clinical Care" October 2006 and Royal College of Physicians Paediatric Stroke Working Group "Stroke in Childhood: Clinical guidelines for diagnosis, management and rehabilitation" 2004.

- Lack of implementations of recommendations as stated in The Royal College of Physicians guidelines on stroke in children.
- Lack of short and long term physiotherapy care plan resulting in preventable permanent disability and mobility
- Lack of a structured response by Department of Education to the need of young stroke survivors

Sickle Cell Disease and its complications are often ignored in mainstream NHS and Department of Health initiatives, for example the recent National Stroke Strategy which made no mention of the link between Sickle Cell and risk of stroke in children, and the fact that stroke can often be prevented in these cases through identification of those at risk and treatment by blood transfusion.

We believe that the NHS needs to do more to reduce the poor health outcomes of sickle cell patients, particularly children with the condition, who are at risk of stroke.

The distribution and quality of GP services and their influence on health inequalities, including how the Quality and Outcomes Framework and Practice-based Commissioning might be used to improve the quality and distribution of GP services to reduce health inequalities;

No Comment.

The effectiveness of public health services at reducing inequalities by targeting key causes such as smoking and obesity, including whether some public health interventions may lead to increases in health inequalities; and which interventions are most cost-effective;

No Comment.

Whether specific interventions designed to tackle health inequalities, such as Sure Start and Health Action Zones, have proved effective and cost-effective;

Widely available targeted education and information on genotypes targeting groups affected by sickle cell disease will be a worthwhile investment as a preventative measure.

The success of NHS organisations at co-ordinating activities with other organisations, for example local authorities, education and housing providers, to tackle inequalities; and what incentives can be provided to ensure these organisations improve care

As an organisation our experience in representing various parents is one of a lack of coordination or co-operation by the NHS with schools (provision of statement, SEN, reporting of silent strokes etc), local authorities, social services—providing respite, Housing—providing adequate housing for now disabled children and even coordination between departments and trusts within the NHS, (eg. lack of coordination of appointments etc).

The effectiveness of the Department of Health in co-ordinating policy with other government departments, in order to meet its Public Service Agreement targets for reducing inequalities;

Objective 2 of the Public Service Agreement Targets is to improve health outcomes for people with long-term conditions by offering a personalised care plan for vulnerable people most at risk. Sickle Cell is a long term genetic condition.

There are currently no long term care plans available for sufferers of sickle Cell. We believe that an established care plan from the onset will provide a care framework and act as a useful tool and a starting point in tackling some of these inequalities.

Whether the Government is likely to meet its Public Service Agreement targets in respect of health inequalities.

SCYSS feels that due to the reasons above, the Government is unlikely to meet the Public Service Agreement objective 2, to reduce health inequalities.

January 2008

Memorandum by the British Medical Association (HI 83)

THE CONTRIBUTION OF THE NHS TO REDUCING HEALTH INEQUALITIES

The British Medical Association (BMA) is an independent trade union and voluntary professional association which represents doctors from all branches of medicine all over the UK. It has a total membership of over 139,000.

EXECUTIVE SUMMARY

- The extent to which the NHS can contribute to reducing health inequalities should be viewed in the context of evident widening inequalities in wealth and other related socio-economic inequalities.
- Some recent and ongoing policy initiatives in the NHS may lead to increasing health inequalities. The Government's "patient choice" initiative is an example of this.
- The NHS as the largest employer in the country has a role to directly and indirectly have an impact on positively reducing health inequalities through employment practice as well as service provision.
- GP services also have a role in reducing health inequalities but this can only be part of a wider approach that needs to be seen in the context of efforts elsewhere to address broader inequalities.
- The Quality and Outcomes Framework (QOF) contributes to a reduction of health inequality by encouraging a uniform standard of care across all practices and across many disease areas. QOF has also allowed the collection of a significant clinical evidence base that can help to inform wider debate on health inequalities.
- In order for Practice Based Commissioning (PBC) to fulfil its potential, GPs need to be given a genuine opportunity to make commissioning decisions that are supported, not led by managers, and adequate resources need to be made available to enable GPs to engage properly with the PBC process.
- In general, the BMA believes that General Medical Services (GMS) and Personal Medical Services (PMS) practices offer the best option for all patients, not just those in better-off areas of towns and cities. The BMA remains very concerned that new Alternative Provider Medical Services (APMS) practices may end up delivering a potentially second-class service to areas of the country that already have significant health inequalities.
- The effectiveness of public health services is reliant on the availability of an appropriately trained, public health workforce and at present the future viability of this workforce is at risk.
- In order to improve the effectiveness of public health services at reducing health inequalities, it is crucial that public health programmes are enabled to cut across different sectors and engage local communities.
- The BMA would question whether Health Action Zones (HAZ) and Sure Start have yet proven to be effective (and cost effective) on a wide-scale, whilst acknowledging that some individual, local schemes have been shown to be of value.
- The level of success of NHS organisations at co-ordinating activities with other organisations has generally been very low and therefore, much more work needs to be undertaken if reliable, integrated schemes are to successfully and consistently reduce health inequalities.
- There needs to be much greater joined-up thinking in government and there should be consideration given to appointing a minister at cabinet level whose responsibility is the health of the public and who would oversee work in every government department to try and facilitate this.

What is the extent to which the NHS can contribute to reducing health inequalities, given that many of the causes of inequalities relate to other policy areas eg taxation, employment, housing, education and local government?

1. The NHS has been, and will continue to be, expected to play a central role in addressing the issue of health inequalities and is presently subject to a set of ambitious targets focused on this objective. Nevertheless, the current efforts of the NHS must be set against the backdrop of a wide-range of evidence that suggests that inequalities in health continued to widen in the 1980s and 1990s, and that, sadly, the expectation is that such inequalities are unlikely to have been reduced by a great margin, if at all, by 2010. Of particular importance is the fact that increasing health inequalities seemingly reflect trends in income inequality, which, in a similar manner to health inequalities have increased in the latter part of the 20th century^{649, 650}.

⁶⁴⁹ Shaw M, Dorling D, Gordon D, Davey Smith G. *The widening gap: health inequalities and policy in Britain*. Bristol: Policy Press, 1999.

⁶⁵⁰ Lakin C. The effects of taxes and benefits on household income, 2002–2003. *Economic Trends* 2004;607: 39–84.

2. Consequently, the extent to which the NHS can contribute to reducing health inequalities should be viewed in the context of evident widening inequalities in wealth and other related socio-economic inequalities. Ultimately, despite recent favourable economic circumstances, and the introduction of initiatives such as the national minimum wage, new deal, and tax credits, it is only with greater redistributive policies targeted at poverty and income inequalities that we might expect to see a sustained reduction in health inequalities. Until such a time, the NHS will continue to strive to address a limited range of the causes of health inequalities and their effects but can do little more than ameliorate many of the wider impacts of socio-economic inequalities on the health of the UK population.

3. A further concern is that some recent and ongoing policy initiatives in the NHS may lead to increasing inequalities, the “patient choice” initiative being a case in point. The former Secretary of State for Health, Patricia Hewitt, stated that “choice is important . . . because—far from entrenching inequality—it will help us create a more equal society.”⁶⁵¹ It is noteworthy that many of the key strategic documents on health inequalities produced by the Government in recent years do not promote the patient choice agenda, nor advocate any form of increased choice—rather the documents tend to encourage uniformity, for example with the introduction of National Service Frameworks.^{652, 653} Our concern is further illustrated by a joint study by RAND Europe, the King’s Fund and City University which found that patients possessing formal educational qualifications were more likely to choose hospitals with higher standards of clinical performance as providers of their treatment. However, patients without formal educational qualifications placed significantly less importance on increases in clinical quality above an “average” level.⁶⁵⁴ In effect, this research suggests that offering patients greater choice risks widening health inequalities.

4. It should also be appreciated that, as one third of inequalities in health are work-related, occupational health services (including occupational psychology) have an important role to play but such services are neither mandatory nor publicly-provided and do not form part of the NHS as currently constituted.

5. The NHS is in a unique position as the largest employer in the country to directly and indirectly have an impact on positively reducing health inequalities through employment practice as well as service provision. As an employer the NHS should proactively engage with inequalities of opportunities still experienced by individuals from minority groups within the NHS, including those with disabilities, from ethnic minorities and lesbian, gay, bisexual and/or transgender individuals. Although some work has been started the lack of standardised full diversity monitoring of staff and that lack of commitment to a fully engaged approach to diversity has created a hierarchy of agendas in trusts which further disadvantages some minorities. Even though the BMA does not support quotas or positive discrimination, the NHS could contribute substantially to reducing inequalities relating to employment through transparent universal monitoring of staff and staff progression to illustrate the effectiveness of interventions in the workplace to tackle discrimination and promote equity of opportunity.

6. Furthermore as an employer of over 1 million staff, the NHS must proactively engage in promoting health and preventing disease for its own workforce. The lack of funding or incentives to address workplace health issues and promote a holistic supportive workplace has led to the NHS being criticised for a lack of engagement on issues such as domestic violence and mental health.

How might the distribution and quality of GP services and their influence on health inequalities, including how the Quality and Outcomes Framework and Practice-based Commissioning might be used to improve the quality and distribution of GP services to reduce health inequalities?

7. GP services do have a role to play in reducing health inequalities, although we would stress that this can only be as a part of a wider approach and must be seen in the context of the efforts required elsewhere to address broader inequalities, as noted above.

8. Continuity of care and the ongoing trust of patients are critical to the work of GPs, particularly when it comes to discussing with patients many of the wider and less tangible lifestyle issues that affect health inequalities. We therefore believe it is essential that continuity of care is preserved. We are concerned that many recent initiatives in Primary Care, such as the introduction of APMS contracts and the move towards more centralised polyclinics, particularly when combined with the freeze in GP practices’ GMS global sum funding over the past two years, could damage this continuity of care.

9. The Quality and Outcomes Framework (QOF) rewards practices where they can demonstrate that they are giving patients the best possible evidence-based treatments in named disease categories. Over the three years that the QOF has been in existence the national prevalence rate of certain diseases has gone up, demonstrating that the QOF is encouraging greater case finding and identifying more patients with chronic diseases. We believe that, by encouraging a uniform standard of care across all practices and across many disease areas (some of which will be higher among the lower social economic strata of society) the QOF contributes to a reduction of health inequality in healthcare.

⁶⁵¹ Hewitt P. The Nation’s Health and Social Change. Discussion Paper, New Health Network, September 2005.

⁶⁵² Acheson D (Chair). Independent inquiry into inequalities in health: Report. The Stationary Office, London, 1998.

⁶⁵³ Department of Health. Tackling health inequalities: A Programme for Action. Department of Health Publications London, 2003.

⁶⁵⁴ Burge, P., Devlin, N., Appleby, J., Gallo, F., Nason, E., and Ling, T. Understanding Patients’ Choices at the Point of Referral, Working Paper, May 2006, Rand Europe.

10. The Adjusted Disease Prevalence Factor (ADPF) used in QOF currently involves calculating payments in relation to disease prevalence. At the time the QOF was negotiated the ADPF was introduced with a 5% lower end cut-off and a square rooting calculation. The 5% cut-off was to protect and compensate smaller practices. All practices will incur significant fixed costs in identifying morbidity and establishing quality systems and the smaller the practice, the higher these costs will be proportionally. The square rooting transformation was introduced initially so that practices would not face large financial swings should some patients with a specific disease leave their practice and alter their disease prevalence. However, over time it has been recognised that the ADPF has unnecessarily protected practices with very low disease prevalence and failed to fully reward practices with a high disease prevalence. In general the highest levels of disease prevalence are found in the poorest areas. There is now an increasing desire amongst GPs and the political negotiating parties to resolve these inequalities and use a True Disease Prevalence Factor. The BMA's General Practitioners Committee (GPC) is currently in discussions with NHS Employers as to the viability of moving from an Adjusted Disease Prevalence Factor to a True Disease Prevalence Factor.

11. Additionally, the introduction of QOF has allowed the collection of a significant clinical evidence base that can help to inform the wider debate on health inequalities.

12. Practice Based Commissioning (PBC) also has the potential to positively affect health inequalities by virtue of the close relationship between GPs and their patient populations, allowing them to identify real needs and structure services that address these needs and result in improved health outcomes. In the current climate, PBC is only really able to focus on demand and resource management and so is not realising its full potential. We would also stress that PBC is primarily about commissioning secondary care services, rather than primary care services, which are commissioned by Primary Care Organisations. In order for PBC to fulfil its potential, GPs need to be given a genuine opportunity to make commissioning decisions that are supported, not led by managers, and adequate resources need to be made available to enable GPs to engage properly with the PBC process.

13. Following recommendations made in the Next Stage Review interim report and subsequent guidelines on procurement issued to Primary Care Organisations, we are concerned by the Department of Health's insistence on the establishment of so many new GP practices under the Alternative Provider Medical Services (APMS) contractual route, a policy which appears to overlook and undervalue the strengths of the traditional independent contractor model delivered through the GMS and PMS route. Private organisations holding APMS contracts employ a salaried or locum staffing model, akin to that of existing Primary Care Trust Medical Services (PCTMS) practices where the turnover of employed doctors is often high, the running costs are higher than GMS or PMS and QOF scores are lower. As we believe that, in general, GMS and PMS practices offer the best option for all patients, not just those in better-off areas of towns and cities, we remain very concerned that these new APMS practices may end up delivering a potentially second-class service to areas of the country that already have significant health inequalities.

14. The commitment to invest solely in new primary care services, rather than improving existing services and/or infrastructures we believe is short-sighted and will not provide value for money. We would wish to see some of this funding going towards GP premises development, allowing for practice expansion. Funding extensions to existing practice premises would allow those practices to increase their list size, improve the level of service and provide a wider range of services to their patients.

15. We are acutely aware that many of the areas with the poorest health outcomes are those which are under-doctored. We would therefore support measures to improve recruitment and retention of GPs in these areas.

What is the level of effectiveness of public health services at reducing inequalities by targeting key causes such as smoking and obesity, including whether some public health interventions may lead to increases in health inequalities; AND which interventions are most cost-effective?

16. The effectiveness of public health services, with particular regard to reducing health inequalities, has been hindered by the continued reorganisation of the NHS that has characterised recent policy initiatives. Public health professionals have been particularly affected and this has compounded a trend which has resulted in significant numbers of senior public health posts being lost over the past 3–4 years⁶⁵⁵. Clearly, the effectiveness of public health services is reliant on the availability of an appropriately trained, public health workforce and at present the future viability of this workforce is at risk.

17. In order to improve the effectiveness of public health services at reducing health inequalities it is crucial that public health programmes are enabled to cut across different sectors and engage local communities. These services must be implemented such that they are regarded as integral to the mainstream delivery of health services. This approach will require PCTs to become much more adept at fulfilling their public health engagement role and will necessitate the efficient use of the capacity of the public health workforce. A vital element of this strategy would be an increased emphasis on public health in performance management in PCTs. To this end we are concerned that PCTs are not statutorily required to have a Director of Public Health (DPH), and local authorities are not required to have a DPH at all. We would support

⁶⁵⁵ The Specialist Public Health Workforce in the UK 2005 Survey: "A Report for the Board of the Faculty of Public Health March 2006". http://www.fph.org.uk/prof_affairs/downloads/workforce/FPH%20Workforce%20Survey%202005.pdf

making this mandatory for local authorities and PCTs, although they could make a joint appointment where their boundaries are coterminous. NHS Trusts (including Foundation Trusts) should also be required to have a public health structure with an appropriate relationship with the DPH of their lead commissioner.

18. Policies to influence the lifestyles people choose need to be tackled on a range of levels—mass media advertising, targeted social marketing, brief interventions by primary care professionals, support for individuals who have decided to make a change, community development and community action to tackle cultural obstacles to healthier choices, and steps to make healthier choices easy to make. (There is, for example, no point encouraging walking and cycling in the absence of attractive walking networks and safe cycle networks or promoting salt reduction if it is impossible to obtain low salt processed food).

19. It is not a question of which of these work. None of them work well in the absence of the others—as integrated programmes they do work. The NHS is the appropriate provider of many parts of this chain but the whole chain will fail if there is a failure of the external interventions in areas outside the health service such as education, housing, transport and so on.

Have specific interventions designed to tackle health inequalities, such as Sure Start and Health Action Zones, have proved effective and cost-effective?

20. The principal of reducing the effects of persistent disadvantage that underpins the rationale for both Health Action Zones (HAZ) and Sure Start is commendable and the BMA is naturally supportive of efforts to address inequality and social exclusion. However, we would question whether either of these initiatives has yet proven to be effective (and cost-effective) on a wide-scale, whilst acknowledging that some individual, local schemes have shown to be of value⁶⁵⁶. The national evaluation of action by HAZs to tackle health inequalities suggests that their direct impact on health inequalities was minimal and highlighted the uncertainty concerning the longevity of the HAZ initiatives, exacerbated by continual shifts in national policy, as a key factor that reduced HAZs' ability to influence local policies.⁶⁵⁷

21. Nevertheless, in considering the relative success of such initiatives one must take into account the size and nature of the task in front of them. HAZs and Sure Start have been tasked not only with addressing the effects of deep-rooted socio-economic inequalities but have been expected to do so through the development of complex partnership coalitions of multiple interests at a time when the NHS has been the subject of significant organisational change and financial pressures. Certainly, an evaluation of these schemes' progress must be sympathetic to this context, if not to those who have engendered it.

22. It is, therefore, perhaps unrealistic to expect early demonstrable progress to have been made and only fair to note that without more effective measures to reduce socio-economic inequalities, the chances of such schemes significantly reducing health inequalities will remain notably inhibited.

What has been the level of success of NHS organisations at co-ordinating activities with other organisations, for example local authorities, education and housing providers, to tackle inequalities; AND what incentives can be provided to ensure these organisations improve care?

23. It is our experience that the level of success of NHS organisations at co-ordinating activities with other organisations has generally been very low. Consequently, much more work needs to be undertaken in this area if reliable, integrated schemes are to successfully and consistently reduce health inequalities. To achieve this it is vital that more schemes that try to provide joined-up, co-ordinated help in this area are adequately piloted.

24. Some positive examples, however, do exist. The Children's Trust has ensured better co-ordination of work with the local authority and other agencies working with children and young people to create tangible change and address inequalities in a more coherent manner. Similarly, the joint-appointment of directors of public health has tangible differences to the working of other partner agencies, especially the local authority sector, in addressing health inequalities.

What is the level of effectiveness of the Department of Health in co-ordinating policy with other government departments, in order to meet its Public Service Agreement targets for reducing inequalities?

25. In recognition of the fact that many of the causes of health inequalities relate to other policy areas, eg taxation, employment, housing, transport, big business, education and local government, the BMA welcomes the Department of Health's undertaking to co-ordinate its work with other government departments in order to meet a number of its Public Service Agreement targets. Indeed, it is imperative that the understanding that health inequalities are greatly influenced by wider determinants of health, founded in socio-economic forces, is entrenched across government.

⁶⁵⁶ National Evaluation of Sure Start (NESS). *Early Impacts of Sure Start Local Programmes on Children and Families*, November 2005. HMSO.

⁶⁵⁷ Benzeval, M (2003) *The Final Report of the Tackling Inequalities in Health Module*. London: Queen Mary, University of London.

26. The example of the Public Service Agreement (PSA) on obesity, published in 2004, is a case in point. This target is jointly owned by the Department of Health, Department for Education and Skills and the Department for Culture, Media and Sport. However, without a detailed evaluation of the progress towards these targets, and of the process of co-ordination undertaken to achieve said targets, at this time it is not possible to reliably judge the level of effectiveness of the Department of Health in this area.

27. Just as the Treasury has an overarching role in relation to ensuring prosperity, we believe that government needs to establish an overarching function to ensure improving health. The Department of Health has an overwhelming preoccupation with health services and has interpreted the role of the Minister for Public Health primarily as directed towards medical interventions for prevention. This must change if the Department of Health is to continue to fulfil the lead role on the health of the people. Certainly, if we are to achieve the Wanless fully-engaged scenario⁶⁵⁸ there needs to be much greater joined-up thinking in government and there should be consideration given to appointing a minister at cabinet level whose responsibility is the health of the public and who would oversee work in every government department to try to and facilitate this.

28. Other alternatives could also be considered. For example, the promotion of health could be effectively linked with other key issues such as sustainability and action to adapt to climate change in a Department of Public Health, the Environment and Social Policy. Or health could be made a major element of Public Service Agreements and the Minister of Public Health could be located in the Treasury. Any of these arrangements would work if there was a determination to have an overarching commitment to health and would fail if there was not. This commitment needs to be led from the top by a Prime Minister prepared to say, as Disraeli said, “the health of the people is the first concern of Government”.

29. One reason we have supported the idea of greater independence for the NHS is so that the Department may spend more time on its public health responsibilities. If there were to be such a reduction in micromanagement and more devolution the element of the Department concerned with NHS matters could be significantly reduced in size. The Department’s remit could then shift to concentrate largely on public health matters and the tackling health of inequalities with much greater attention paid to its remit involving social care.

Is the Government likely to meet its Public Service Agreement targets in respect of health inequalities?

30. No. Most areas are behind the trajectories needed as a result of the persistent restructuring of the NHS and the lack of investment in the public health workforce.

January 2008

Memorandum by Dr Ramesh Bhatt (HI 84)

The extent to which the NHS can contribute to reducing health inequalities, given that many of the causes of inequalities relate to other policy areas eg taxation, employment, housing, education and local government

The determinants of patient health are more or less outside the control of the NHS as are several of the outcomes; evidence of healthcare providers compensating for this exists—such as length of consultation with GP and deprivation—where opportunity allows, GPs consult for longer with patients from deprived backgrounds.

The distribution and quality of GP services and their influence on health inequalities, including how the Quality and Outcomes Framework and Practice-based Commissioning might be used to improve the quality and distribution of GP services to reduce health inequalities;

The history of resource allocation for general practice has an all too familiar ring of “inverse care law” ie disproportionate resources allocation to most well off communities. Sadly this continues to be the case right up to the present time—rather well demonstrated by the use of the square root formula in the new GP Contract.

⁶⁵⁸ Wanless, D. (2002) *Securing our future health: taking a long-term view*. London: HM Treasury.

The effectiveness of public health services at reducing inequalities by targeting key causes such as smoking and obesity, including whether some public health interventions may lead to increases in health inequalities; and which interventions are most cost-effective;

Public Health intervention will only be effective if it is co-ordinated with other agencies and initiatives. We see several major morbidities which have their roots in life style choices exacerbated by other policy initiatives such as powerful supermarkets and food industries lobbying for ever expanding processed food markets, out of town developments necessitating use of cars and destroying local communities and selling off of recreational facilities to property developers by local authorities. Smoking ban is a welcome change of direction to this relentless process.

Whether specific interventions designed to tackle health inequalities, such as Sure Start and Health Action Zones, have proved effective and cost-effective;

Unable to comment—through little feedback from any of my patients.

The success of NHS organisations at co-ordinating activities with other organisations, for example local authorities, education and housing providers, to tackle inequalities; and what incentives can be provided to ensure these organisations improve care

As a GP, I am disappointed at the lack of effective cross-Sectoral working despite clear potential for this. Potential areas for collaboration include prescribing exercises, local recreational facilities and assistance with memberships local gyms for patients with significant disease laud such as diabetes, obesity, arthritis and so on. An anti obesity drug prescribed by the GP can cost up to £35/month which could more than cover assisted gym membership.

The effectiveness of the Department of Health in co-ordinating policy with other government departments, in order to meets its Public Service Agreement targets for reducing inequalities; and

Unable to comment as I am not entirely sure about the details of the targets.

Whether the Government is likely to meet its Public Service Agreement targets in respect of health inequalities.

Unable to comment as I am not entirely sure about the details of the targets

Dr Ramesh Bhatt, GP

January 2008

Memorandum by the Healthcare Commission (HI 85)

HEALTH INEQUALITIES

The Healthcare Commission welcomes the focus being given to health inequalities by the Health Committee's New Inquiry.

The Healthcare Commission was formed by the Health and Social Care (Community Health and Standards) Act 2003, and launched on April 1st 2004. Our role includes a duty to promote improvements in healthcare and we are the only regulator in the world with a statutory responsibility to assess healthcare organisations in relation to their public health delivery.

In accordance with the terms of reference of the inquiry, our response is laid out under the published headings—points 1 to 7. We identify health inequalities in relation to population health outcomes. Public health is a key area in relation to health inequalities and we focus on this in a number of points. Inequalities in access and quality of care contribute to population health outcomes, and are included in our response where appropriate (for example, in point 2, GP services).

In the first three years of the Healthcare Commission's existence, we have made considerable progress in ensuring that public health and particularly the tackling of health inequalities are central to our work and we continue to keep this focus. We have assessed all healthcare organisations on the standards for public health and the new and existing national targets, many of which address population health and health inequalities. We have produced regional reports on the results of these assessments and we would be pleased to share that information⁶⁵⁹.

⁶⁵⁹ We intend to make the regional reports accessible to the public via our website in early 2008.

We have conducted a number of improvement reviews, including one of all primary care trusts (PCTs) on tobacco control that fed into the annual health check ratings for the year 2005–2006 and resulted in a national report⁶⁶⁰. We have also conducted in-depth studies on sexual health⁶⁶¹, unintentional injury in the under 5s⁶⁶², childhood obesity⁶⁶³, diabetes⁶⁶⁴ and chronic obstructive pulmonary disease (COPD)⁶⁶⁵ all areas where health inequalities are in evidence. Our annual State of Healthcare Report to Parliament has a focus on health inequalities.⁶⁶⁶

It should be noted that a number of points raised in this submission come from recent work to be published in early spring 2008—*Are we choosing health?*, a review of the past ten years of policy and its impact on public health service delivery. We would be happy to provide a copy when it is published.

EXECUTIVE SUMMARY

1. Continued focus on health inequalities—for Government, local strategic partnerships, commissioners and providers: The Government should be congratulated on taking bold steps in setting standards and targets relating to health inequalities. However, the gap in health status between those people who are affluent and those for whom deprivation is a reality remains wide and shows little sign of narrowing. Efforts need to be maintained and expanded in the future.

2. Clearly the NHS cannot carry the entire burden of reducing health inequalities. NHS organisations must lead or support others to lead joined-up action across a local area to encourage the reduction of local health inequalities. The NHS does, however, hold several key roles in which it is able to contribute independently towards reducing health inequalities. These include both the commissioning and provision of programmes and services, improving staff health and contributing to the broader local economy in its role as the largest employer in England.

3. A more coherent approach across the public sector (and with the private and third sectors) is necessary to enable health, social care, housing, and education needs to be met and linked together for sustainable impact. Local area agreements should be focused to ensure a joined-up approach contributes to reducing health inequalities.

4. Role for regulation: Including public health and health inequalities in Standards for Better Health and within the Healthcare Commission's remit has had a positive impact across healthcare providers. Evidence from our assessments as well as our reviews and engagement with stakeholders suggests that provider trusts and PCTs have made considerable progress in developing work to tackle health inequalities as a result of the inclusion of public health and health inequalities within regulation.

5. Currently the Healthcare Commission assesses PCTs on how they invest and disinvest in services and programmes in relation to the needs of the whole local population, and particularly those with the greatest health needs. The Government's plans for a Joint Strategic Needs Assessment in each area will support PCTs to further develop this work with their partners.

6. We share strong concerns raised by public health professionals about the need to maintain and build on the progress that our assessment has provided. Currently the Bill setting up the new Health and Social Care Regulator does not include a remit to consider crucial areas of public health as part of registration requirements in provider trusts. Furthermore the future for the Standards for Better Health is very uncertain.

7. It is critical that public health is included within the remit of the new Health and Social Care Regulator, building on work to date by the Healthcare Commission and the Department of Health. This should link with regulation across sectors (such as Comprehensive Area Assessments as well as the role of Strategic Health Authorities in performance management) and cover both commissioning and provision of services.

8. Primary care provision: GPs need to be more involved in maintaining and improving patient health. We welcome the recent announcement by the Prime Minister on the introduction of health checks and an increase in screening opportunities to prevent illness. However, in order for these initiatives to impact positively on health inequalities it is important for plans to be in place to target those most in need—and to provide sensitive services for treatment and support.

9. There should be less variation across GP provision, particularly between single-handed and group practices. An effective incentive and resource framework is vital to make a difference to health inequalities and therefore the Quality and Outcomes Framework (QOF) needs to be revised to give sufficient incentives for health promotion and to ensure local government, PCTs and healthcare and local government organisations work together to provide joined-up wellbeing work. We suggest the new health and social care regulator has a role to complement and support the role of the PCT and SHA in improving standards in primary care.

⁶⁶⁰ *No ifs, no buts: Improving services for tobacco control* (2007).

⁶⁶¹ *Performing better? A focus on sexual health services in England* (2007).

⁶⁶² *Better safe than sorry: Preventing unintentional injury to children* (2007) (a joint report with the Audit Commission).

⁶⁶³ *Tackling child obesity—first steps* (2006) (a joint report with the Audit Commission and National Audit Office).

⁶⁶⁴ *Managing diabetes: Improving services for people with diabetes* (2007).

⁶⁶⁵ *Clearing the air: a national study of chronic obstructive pulmonary disease* (2006).

⁶⁶⁶ All reports are available on our website www.healthcarecommission.org.uk

10. Effectiveness: Further evidence of what works is needed for all health inequality issues. Currently there is good evidence for some areas, such as teenage pregnancy where both conventional research and innovative approaches to lesson learning have been used. This needs to be more systematically developed across topic areas. Obesity is an area where lack of information on children's weight has meant that tracking progress has been impossible, accountability at different levels (national, regional and local) is unclear, and targeting of programmes has therefore not been as effective as it should have been.

11. There is a need for better comparative information that shows whether local NHS and local authorities are making a difference (after taking account of differences in deprivation and demographics). Learning can take place by identifying key factors and approaches demonstrated by those areas performing better or worse than their peers.

12. Experience shows effective initiatives have usually benefited from some national capability for understanding, disseminating and developing best practice. NICE provides an important role in developing guidance and the Department of Health's national support teams give valuable support to those healthcare organisations most at risk of not delivering against national targets but in our view a proactive role with all healthcare organisations does not lie anywhere. There is a need for this explicit function at a national level to ensure that everyone performs at their best in delivering services and programmes to tackle health inequalities.

RESPONSE

Point 1: The extent to which the NHS can contribute to reducing health inequalities, given that many of the causes of inequalities relate to other policy areas eg taxation, employment, housing, education and local government

13. Undoubtedly the NHS cannot carry the entire burden of reducing health inequalities. It does, however, hold several key roles in which it is able to contribute towards reducing health inequalities. These include both the commissioning (purchasing) and provision of programmes and services. Also important are the health improvement opportunities that arise in the role of the NHS as the largest employer in England. In addition PCTs have a statutory responsibility to work with partners to improve health and reduce health inequalities within their local populations. (See point 5 of this response).

14. The requirement for the NHS to contribute to reducing health inequalities is currently set in statute. In *Standards for Better Health* (which applies to the provision of all NHS services across settings and which we assess as part of the annual health check), there is a requirement for each standard to be interpreted and implemented so as to challenge discrimination, promote equality of access and quality of services and support the provision of services appropriate to individual needs, preferences and choices.

15. The seventh domain of *Standards for Better Health* (C22 a & c and C23) contains specific elements to reduce health inequalities between different population groups and areas. Performance in this domain has already improved across all sectors in the two years the Healthcare Commission has carried out this assessment. In autumn of 2007, we conducted a survey of directors of public health. Findings were very positive and suggested that the inclusion of public health in the standards and regulation has already had a significant impact on raising and maintaining awareness, commitment and activity among both PCTs and provider trusts.

16. The considerable progress that PCTs and provider trusts have made in relation to health improvement was made even more evident to us through several events held by the Healthcare Commission. These included roundtables for senior national, regional and local professionals in public health and a successful series of large regional events for provider trusts to consider their progress in meeting the public health standards and to share good practice. Their examples demonstrated a growing commitment to public health and activities for tackling health inequalities as a result of our assessment. Among providers there was a commitment to systematically assess patients' needs for health promotion and health protection along their care pathways as well as a focus on staff health. Among PCTs there was evidence of linking local health needs assessment (including health inequality audit) to investment or disinvestment in commissioned programmes or services. We can provide these examples if requested.

17. We share the strong concerns raised by public health professionals about the need to maintain and build on the progress that our assessment has provided. Currently the Bill setting up the new Health and Social Care Regulator does not include a remit to consider crucial areas of public health as part of registration requirements and it is unclear how the new Health and Social care regulator will continue to assess improvement including how commissioning reflects local health needs. Unless this is rectified valuable ground in tackling health inequalities in the work of both provider trusts and PCTs will be lost.

18. At a time when obesity, unintentional injury, sexual health, alcohol, smoking and substance misuse (all with inequality dimensions) are national concerns, inequalities in life expectancy stubbornly persist, and the threat from climate change, avian flu and terrorist attacks remains ever-present (all also with an inequality dimension), The Department of Health may want to ensure that the regulatory levers that are clearly helping to deliver improvements in tackling these issues are maintained.

Point 2: *The distribution and quality of GP services and their influence on health inequalities, including how the Quality and Outcomes Framework (QOF) and Practice-based Commissioning might be used to improve the quality and distribution of GP services to reduce health inequalities*

19. PCTs have a key function in ensuring GP—and wider primary care—services are appropriately situated and of high quality. As the front line of primary care, GP services are fundamental to public health in their role of addressing the primary risk factors of the highest causes of morbidity or mortality.

20. The Healthcare Commission has recently used QOF data to carry out analysis on diabetes and coronary heart disease (CHD), focusing on the association between deprivation and single-handed GPs. This analysis showed considerable variation in practice level performance.

21. Our work suggests that more deprived areas, while not under-doctored in relation to population size, are under-doctored in relation to the greater levels of need in deprived areas. Although in the past deprived areas were under-doctored, this appears to have been remedied by the introduction of salaried GPs. Taking coronary heart disease as an example, we found that practices with lower QOF scores for the management of blood pressure and cholesterol were more likely to be more deprived and to be single-handed than higher achieving practices. Single-handed practices were also significantly more likely to have higher non-elective admission rates for both CHD and diabetes, which suggests that early intervention is not available in those practices.

22. QOF is limited by the completeness of available data, as it can capture information only on people registered with a GP. For example, itinerant populations and newly arrived immigrants are rarely registered; anecdotally, in parts of London up to 25% of the population at any one time is not registered with a GP. This highlights the role for PCTs in ensuring that this is remedied.

23. To better contribute to reducing health inequalities, QOF data needs to be revised to give sufficient incentives for health promotion and to ensure PCTs, healthcare providers, local government and local government services provide joined-up health and wellbeing services. QOF reports should be made accessible to the public. Early access to services (health promotion, screening and treatment) and referral to hospital as appropriate should be the aim for all patients—particularly population groups known to access healthcare only in extreme circumstances—and should be the subject of incentivisation and performance assessment.

24. While PCTs should be encouraged to closely monitor QOF performance at practice level, QOF analysis alone cannot give a comprehensive assessment of the extent of care pathway inequalities. Therefore, monitoring of QOF performance should be carried out in conjunction with the monitoring of other related data sources, such as hospital episode in-patient and out-patient statistics and prescribing data.

Point 3: *The effectiveness of public health services at reducing inequalities by targeting key causes such as smoking and obesity, including whether some public health interventions may lead to increases in health inequalities; and which interventions are most cost-effective*

25. Almost half of PCTs scoring “excellent” in our review of tobacco control performance were from deprived areas. The delivery of high quality services in these areas is a positive step towards improving the health of those communities that traditionally carry a higher burden of disease and we were provided with several examples of good practice of targeting at risk groups within communities. Historic investment was shown to contribute to continued improvement in performance. However, there are pockets of deprivation in all areas, and many PCTs, especially those in more affluent areas, were not yet successfully targeting small areas or population groups known to have high levels of smoking.

26. The model for tackling teenage pregnancy was considered by our group of experts to have been very positive and influential in the reversal of an upward trend in under 18 conceptions. The key components appear to be the development of a national strategy and national targets with a mandatory requirement for a locally agreed strategic plan and locally tailored targets; a national, regional and local infrastructure (staffing and performance management); and resources. Engagement at the highest ministerial level guaranteed the attention and involvement of decision makers. Successful aspects of this model should be considered for use in other programmes, such as obesity, although the current reduced role of central departments in providing direction could limit the effectiveness of this approach.

27. Other examples of effective public health services include NHS stop smoking services, although our assessments suggest worsening performance in this area, this is disappointing given the success of the smoke free public place legislation. Areas such as obesity, unintentional injury, mental health and older people have fared less well as described below.

28. Tackling overweight and obesity and related health inequalities should be a key element of the performance management framework for regional bodies. Our report on childhood obesity⁶⁶⁷ made several recommendations for fundamental elements required to effectively tackle obesity. Departments should provide guidance on data collection as well as evidence about effective approaches, including targeted programmes. PCTs, local government and local services should be encouraged to provide joined-up services, including targeted, sensitive and effective programmes for those most at risk of overweight and obesity and

⁶⁶⁷ *Tackling child obesity—first steps* (2006) (a joint report with the Audit Commission and National Audit Office).

support for people who are obese. All relevant programmes should be adapted to ensure that health inequalities in relation to obesity are taken into account, such as ensuring access to healthy foods and leisure facilities in deprived areas.

29. People with severe and enduring mental health conditions experience poorer health outcomes, with a high risk of, for example, obesity, diabetes and smoking. Some black and minority ethnic groups have higher rates of admission and detention in mental health hospitals than the average population and are more likely to be referred via the criminal justice system, yet they have lower rates of referral from primary care⁶⁶⁸. This does not necessarily reflect the health status of people from BME communities, but suggests a lack of provision and access to primary care and health service providers for people, such as refugees and asylum seekers, and Roma, Gypsies and travellers. This lack of provision and access should be addressed to prevent people from these communities accessing healthcare at a later point in the chain, when factors/symptoms have worsened and can be further compounded by issues such as associated crime or homelessness.

30. Older people face problems with access and quality of care in general, with access to GPs a particular problem. Data shows that older people in deprived areas have higher tooth loss, reduced access to essential but low-level foot care affecting mobility and wellbeing, inadequate access to intermediate and specialist mental health care and difficulties in accessing GPs at night and at weekends. Poor mobility and lack of access to appropriate transport further hinder the effective care of this group. Health services offered to older people from minority groups where they form a small proportion of a community are even less developed, and patients are forced to rely on relatives to share the burden of care.

31. NICE⁶⁶⁹ have published a range of clinical guidelines and health intervention and programme guidance on clinical and public health issues and continue to develop guidance outlining effective methods of addressing health inequalities. Our assessment of the standards is designed to ensure organisations use evidence of effectiveness including NICE guidance. We remain concerned that as yet, public health is not included within the legal remit to assess registration requirements for all healthcare providers, and hope this decision will be reversed. In addition we would want to see broader public health delivery contained within the new standards to promote improvement in commissioning and provision.

32. Even with published guidance in some areas, a challenge faced in using public health interventions is the lack of evidence of effectiveness. This is widely recognised in the field of health improvement and was recently raised in a series of workshops we held in the summer of 2007. Participants felt that there was a general lack of evidence in relation to health improvement delivery, and that where research did exist it was often hard to interpret. On occasion, commissioners were reported to believe that “a lack of evidence about an intervention suggests that the intervention doesn’t work” while in reality it simply indicates that its effects are not yet proven.

33. In order to improve effectiveness it is essential that data collection and analysis improve. This should include:

- ethnicity in birth and death registration records to facilitate targeted programmes to contribute to addressing inequalities
- occupational status of primary carer in birth registration records (to prevent the exclusion of sole registered children from classification of socio-economic status)
- increased data at neighbourhood level
- improvements to programme budgeting for use as a tool for tracking resources in health improvement programmes and services
- datasets being in line with the Department of Health’s 2007 guidance, *Informing Healthier Choices: Information and Intelligence for Healthy Populations*

34. Evidence shows that public health interventions can have the unintended consequence of increasing inequalities either as a result of a delivery or take-up differential between different socio-economic groups. Consequently, initiatives must be thoroughly “proofed” before implementation to ensure they will not exacerbate inequalities. An upstream focus is important to address those most at risk at an early stage, rather than attempting to change learned behaviours or conditions (for example, in relation to smoking and obesity). Government, Department of Health and the NHS need to work together to identify the future causes of morbidity and mortality in 25 plus years time and start to build and implement strategies to address those issues now.

⁶⁶⁸ Count Me In Census.

⁶⁶⁹ www.nice.org.uk/guidance.

⁶⁷⁰ Results of this review have been published at individual PCT level against a detailed framework on our website www.healthcarecommission.org.uk and a national report *No ifs, no buts; improving services for tobacco control* has been produced in electronic and hard copy format.

Point 4: Whether specific interventions designed to tackle health inequalities, such as Sure Start and Health Action Zones, have proved effective and cost-effective

35. In our tobacco control improvement review⁶⁷¹, we found evidence of a positive legacy from Health Action Zones and more recently the spearhead initiative. The additional funding and focus provided by these initiatives appeared to contribute to above average performance in these areas.

36. Regeneration monies were also used to great avail by many organisations. Participants at our recent workshops considered these initiatives key in developing and delivering local public health programmes. However, a note of caution was raised in relation to the sustainability of ring-fenced/time-limited funding streams, as frequently, those areas in receipt of additional funding became a lower priority for mainstream finance.

Point 5: The success of NHS organisations at coordinating activities with other organisations, for example local authorities, education and housing providers, to tackle inequalities; and what incentives can be provided to ensure these organisations improve care

37. Clearly, the NHS cannot address the issue of health inequalities single-handedly, (especially given the emphasis on mortality differentials in the targets rather than, for example, quality of life). NHS organisations must lead or support others to lead joined-up action across a local area to encourage the reduction of local health inequalities. We welcome Comprehensive Area Assessments (CAAs), Joint Strategic Needs Assessments (JSNAs) and Local Area Agreements (LAAs), although we have concern about how health priorities will be chosen locally, and to what extent health inequalities will be included.

38. We highlight the need for these models of joint working (CAAs, JSNAs, LAAs) to be complemented by in-depth regulation. Our recent survey of directors of public health shows how significant our assessment has been in driving forward partnership work. Our in-depth reviews and assessment of the public health developmental standard have revealed examples of good practice in working with local partners to achieve improvements in public health. A key characteristic of high performing PCTs in our tobacco control improvement review, for example, was their engagement in partnerships with local agencies such as councils, hospitals and prisons. In our report on child obesity we detail the role each of the delivery partners can play to strengthen the delivery chain.

39. Publication of comparative data can drive improvement, as such all regulators and auditors need to be able to access standardised information across sectors.

Point 6: The effectiveness of the Department of Health in coordinating policy with other Government departments, in order to meet its Public Service Agreement targets for reducing inequalities

40. To meet the PSA for reducing health inequalities, the Department of Health needs not only to work with other Government departments, but also to ensure that there is co-ordination between sections of its own department. A focus solely on treatment and care and not disease prevention and health promotion will have limited impact on health inequalities. Improving health needs to go hand in hand with tackling health inequalities in order to achieve the Wanless “fully engaged” scenario.

41. Health inequalities are much broader than health; to address them effectively requires engagement across Government departments. For example, public health issues are rarely considered early in plans for regeneration, which often features licensed bars, thus adding to the potential for increased obesity and alcohol consumption. Transport plans also have the potential to influence public health for the better by encouraging use of sustainable public transport or bicycle/walking routes. We welcome wider Government PSAs with the potential to have a positive impact on the health of the public, such as the increase in provision of long-term housing supply and affordability and the agreement to improve children and young people’s safety.

42. Obesity has to date lacked a coherent cross-Government strategy and the infrastructure and resources to deliver. That this target is jointly owned by two Departments is a positive, yet challenging development. At a national level, the Departments have to align priorities for child obesity with their other PSA targets, and a number of other departments, such as the Communities and Local Government, the Department for Transport and the Department for Culture, Media and Sport will need to make significant contributions to ensure delivery of the target. This joined-up working will need to be reflected at regional and local levels.

43. Over recent years, the Government and the Department of Health have undertaken several reorganisations, which have created opportunities for new approaches, but have also threatened delivery. Examples discussed in our workshops included *Shifting the Balance of Power* for PCTs, PCT reconfiguration and the creation of Children’s Directorates in local authorities. Attempts to make PCTs coterminous with local authorities were welcomed in the long term, but the disruption caused has taken time to settle and has compromised relationships and mature partnership arrangements.

⁶⁷¹ Results of this review have been published at individual PCT level against a detailed framework on our website www.healthcarecommission.org.uk and a national report *No ifs, no buts; improving services for tobacco control* has been produced in electronic and hard copy format.

44. To date, while there have been sustained attempts in policy to improve health and tackle inequalities in health, some non-aligned priorities from Government departments have made achieving local coherence challenging. For example, public health experts participating in our recent series of roundtable discussions found that policy seeking to promote patient choice in services inhibited progress in promoting equity of access, potentially benefiting some people over others. Sex and relationship education within Personal, Social and Health Education (PSHE) training is not mandatory, which potentially conflicts with achievement of the teenage conception target.

45. Co-ordination among Government departments needs to go beyond policy, and address, for example, data collection.

Point 7: Whether the Government is likely to meet its Public Service Agreement targets in respect of health inequalities

46. Performance to date would suggest that current health inequality PSA targets will not be met. However, this should not be viewed as failure. We believe that without these targets, the situation would have been worse. In combination with the health inequalities elements of other related targets, the target has provided a focus for commissioners and service providers and has driven improvement in several areas including teenage pregnancy, infant health, tobacco control and life expectancy. We therefore congratulate Government on setting the target and establishing a Health Inequalities Unit. These were brave decisions and gave a strong message, raising the profile of health inequalities and adding to the debate.

47. The short term nature of the targets is, however, of concern, as it has tended to focus action on the mid-fifties plus age group. Increased mortality in this group has the most immediate effect on life expectancy tables. Longer term targets would have encouraged focus on health promotion and preventative action in younger people to enable them to live longer, healthier lives and potentially have a positive impact on NHS resources and services in the future.

Anna Walker
Chief Executive

Jude Williams
Head of Public Health

January 2008

Memorandum by the NHS Sickle Cell and Thalassaemia Screening Programme (HI 86)

HEALTH INEQUALITIES

SUMMARY

- Antenatal and newborn screening of high-risk patients can reduce levels of health inequalities but only as long as services are delivered in an acceptable and accessible manner. The development of screening services allowing for equal access is not only a legal requirement (The Race Relations Act Amendment 2000, Human Rights Act (1998), Disability Discrimination Act 2005, The Equality Bill 2005), but also an ethical obligation to the population that all antenatal and newborn screening programmes cover.
- The implementation of the NHS Sickle Cell and Thalassaemia Screening Programme (“the Programme”) has gone some way to reduce health inequalities across England, particularly for minority ethnic groups. The Programme is specifically working to reduce health inequalities in these key areas:
 - Improving Access to services
 - Reducing Infant Mortality Rates

1. INTRODUCTION: ABOUT THE NHS SICKLE CELL AND THALASSAEMIA SCREENING PROGRAMME AND THE DISEASES

1.1 The NHS Sickle Cell & Thalassaemia (SC&T) Screening Programme was set up in England in 2001 following Government commitment in the NHS Plan (2000). It is the world’s first linked antenatal and newborn screening programme.

1.2 Sickle cell and thalassaemia are among the world's most commonly inherited genetic diseases. In England sickle cell disease is as common as cystic fibrosis. As these are genetic diseases, sickle cell and thalassaemia can affect anyone, but have a higher prevalence among specific, well defined black and minority ethnic groups:

- The highest prevalence of sickle cell is found among Black Caribbean, Black African and Black British communities
- The highest prevalence of thalassaemia is found among Cypriot, Indian, Pakistani, Bangladeshi and Chinese communities

Sickle cell and thalassaemia are autosomal recessive disorders ie Carriers who only have one unusual gene are healthy and do not have a condition, however if 2 carriers have children they have a 1 in 4 (25%) chance with each pregnancy of having a child that does have the condition,
<http://www.sickleandthal.org.uk/Documents/RiskCardForMidwives0822.pdf>

Given the increasingly integrated and diverse society in England, health professionals and the public at large need to know that assumptions about who will be affected based on skin colour or surname are no longer sufficient—everyone needs to consider screening for these diseases..

1.3 Sickle Cell Disease covers a range of conditions—some more serious than others. The most serious form is sickle cell anaemia (Hb SS) but there are other forms of the condition such as sickle haemoglobin C disease (Hb SC) and sickle beta thalassaemia (Hb S β Thalassaemia). The conditions affect the normal oxygen carrying capacity of red blood cells. The symptoms can include severe anaemia, intense pain, damage to major organs, overwhelming infections and stroke in children. Although there is no routine cure for sickle cell disease, patients and their families can be supported to manage pain, and regular monitoring (such as Transcranial Doppler Scanning) can help to avoid life threatening complications such as stroke in children. In England, 12,500 people live with sickle cell disease and an estimated 240,000 people carry the gene and could therefore pass the disease onto their children.

1.4 Beta thalassaemia major is the most severe form of thalassaemia. The body is unable to produce haemoglobin—the element in blood that transports oxygen. Patients therefore need regular blood transfusions every 4–6 weeks throughout their lives. They also need daily treatment to deal with the iron overload that builds up in their body as a result of the transfusions. Complications include diabetes, growth problems, and problems with puberty or early menopause. In England, around 700 people are living with β thalassaemia major with an estimated 214,000 carriers.

1.5 The Programme was set up to implement antenatal screening for sickle cell and thalassaemia and newborn screening for sickle cell disease throughout England. All newborn babies are now being offered screening for sickle cell disease as part of the bloodspot (“heel prick”) tests.
<http://www.sickleandthal.org.uk/Documents/StakeholderEvent06.pdf>. The full implementation of antenatal screening is planned for 2008.

1.6 The overall aims of the programme:

Antenatal Screening:

To offer timely antenatal sickle cell and thalassaemia screening to all women (and couples) to facilitate informed decision-making.

Newborn Screening:

To achieve the lowest possible childhood death rate and to minimize childhood morbidity from sickle cell disease.

Raise health care professional and public awareness of the disorders and challenge stigma

Additional to the original remit, the Programme is supporting,

- Developments to offer a screening test to people before they start a family
- Developments for a managed clinical care network such that people have fair access to quality services throughout England, irrespective of where they live

1.6.1 The Programme is currently rolling out antenatal screening across England. The Programme aims to offer all pregnant women the initial screening test by 10 weeks of pregnancy. Where a woman is a genetic carrier, the baby's father is also offered testing. If both parents are carriers (an at risk couple), there is a one in four chance with each pregnancy that the baby will have a disorder (either sickle cell or thalassaemia). At risk couples will be offered a range of counselling and diagnostic tests for the baby. Antenatal screening for sickle cell and thalassaemia has been rolled out in most high prevalence areas (defined as estimated foetal prevalence of sickle cell disease of over 1.5 per 10,000 births). In low prevalence areas (estimated foetal prevalence of sickle cell disease of less than 1.5 per 10,000 births), all women will be offered screening for thalassaemia and a questionnaire looking at family origin of both the woman and baby's father will be used as an initial screen to assess risk for sickle cell and other haemoglobin variants
http://www.sickleandthal.org.uk/Documents/F_Origin_Questionnaire.pdf.

1.6.2 Since July 2006, screening for sickle cell disease has been offered to all babies as part of the newborn blood spot or “heel prick” test. Screening identifies approximately 300 babies a year who would be at a higher risk of death from overwhelming infections and other complications.

1.6.3 The Programme is the process of developing accessible materials in a range of languages and formats to improve access to services. The programme has also commissioned a “pilot” public outreach project targeting communities that have experienced barriers to accessing services, to raise awareness about the conditions and screening services generally. The Programme has also commissioned a range of training and education initiatives since 2001 for key health care professionals raising awareness about the conditions and ensuring they were ready for service implementation. The largest of which was the PEGASUS network which has implemented professional training at 3 levels:

- Front line professionals (midwives, Health visitors etc)
- Public Health (Public Health Consultants, Commissioners etc)
- Specialist Practitioners (Professional who will counsel couples at risk)

1.7 The Programme has been working with the Department of Health Blood Team in the identification of funding for the provision of managed clinical care networks and support of those affected by sickle cell and thalassaemia. Managed care is not only important in relieving suffering, but also cost effective in reducing the cost of specialist interventions. The Programme has also supported the largely professional body—UK Forum for Haemoglobin Disorders in the development of clinical care guidelines. Many of the strategies planned will help families to spot warning signs and take early action. This, in turn, will reduce complications that are more likely if a patient is not adequately managed and are more expensive for the NHS in the longer term.

EFFECTIVELY TACKLING HEALTH INEQUALITIES: IMPROVING ACCESS TO SERVICES

2.1 When effective newborn screening provides relatively easy access to services to manage the conditions for those affected. The roll-out of newborn screening for sickle cell in 2006 enables all babies with sickle cell to be identified early, allowing for care to be administered and families to be educated about the conditions and be involved in the management.

2.2 Timely and effective antenatal screening for sickle cell and thalassaemia has also improved access to services. The development of the family origin questionnaire has enabled health care professionals to be at ease at asking women about their and the baby’s father family origins, thus ensuring that all those at risk of sickle cell and other haemoglobin variants are offered screening.

2.3 It is generally accepted that more women and families would have greater choice and find the process far more acceptable if the standards for early screening for sickle cell and thalassaemia were met. One of the key barriers to accessing care is the system for reporting and confirming a pregnancy. Pregnant women usually present to primary care in the first instance, however, there can be a detrimental delay in the referral to a midwife for the standard “booking appointment” and taking of the blood for the screening tests. Data from the SHIFT Trial (in press) shows that most pregnant women first present at their GP surgeries at an average gestation age of 7.6 weeks but testing takes place, on average at 15.3 weeks. Only 4.4% of pregnant women are screened by out guideline of 10 weeks. With the current arrangements in antenatal/ maternity services this standard is difficult to reach.

2.4 A possible solution is that primary care services or practice based medicine offer the initial test before the traditional booking appointment. We also believe that by considering the option of screening for sickle cell and thalassaemia in the pre-conception, primary care could significantly reduce inequalities in this area and improve access to maternity services and choice for screening. In the same way as advice on taking folic acid and smoking cessation is offered, screening could be offered as part of routine health checks; when individuals register with a GP, during family planning appointments, as well as when pregnant woman presents. Currently GPs have a QoF system that covers antenatal care, this could be further clarified to include the offer of screening for sickle cell and thalassaemia and the family origin questionnaire, thus improving the likelihood that this standard is met. The need to look at options will be pushed up the agenda if as anticipated the NICE antenatal care guidelines endorse the implementation of the Programmes standard for screening by 10 weeks.

2.5 The UK National Screening Committee (NSC) has produced a screening timeline that is currently available to women as part of the pre-screening and newborn screening information on all antenatal and newborn programmes. The timeline highlights optimum times for testing of all antenatal and newborn screening programmes including screening in the pre conception period and early pregnancy for the sickle cell and thalassaemia programme...

EFFECTIVELY TACKLING HEALTH INEQUALITIES: REDUCING INFANT MORTALITY RATES

3.1 In 2005–06 alone the newborn screening programme for sickle cell disease identified about 300 affected infants. There is well validated evidence that with effective follow up, education of parents/carers and adequate management of these babies there is a significant improvement in their morbidity and mortality rates. The newborn programme alone is expected to contribute a reduction of approximately 15 deaths per year to the infant mortality PSA target.

3.2 Implementing screening for these diseases which predominantly affect black and minority ethnic groups also has the potential to impact on groups acknowledged by the Review of Health Inequalities Infant Mortality PSA Target report to suffer from a higher than average rate of infant mortality. In particular, there is a higher than average ethnic minority population in the “routine and manual group” compared to the general population.

3.3 To ensure that these achievements can really be delivered there are challenges and decisions to be made about continual investment in the services for the care of these babies and children beyond the initial three month remit of the newborn screening programme.

3.4 Timely and effective antenatal screening can also affect the outcomes of pregnancy. Antenatal screening is designed to increase choice but the ethical framework for testing is seriously undermined if parents cannot choose to have an affected baby in the knowledge that they can access quality care and support, for example through referral to a centre of excellence. And services for those living with sickle cell and thalassaemia still suffer when compared either to other chronic genetic disorders such as cystic fibrosis or to other blood disorders like leukaemia.

3.5 The Programme is working with the Department of Health Blood Team to develop a managed clinical care network which would tackle the current inequalities and unevenness in the provision of care of affected children. Such a network would have a strong focus on primary care and tie into wider programmes aiming to improve the care of individuals living with chronic conditions by the proactive management of their conditions in the community.

4. RECOMMENDATIONS

4.1 It should be the responsibility of all primary care professionals to consider the appropriateness of screening for their patients. Not just for pregnant women (who should be offered screening for sickle cell and thalassaemia before 10 weeks) but as a service proactively offered to high-risk or all individuals at opportunistic points in care.

4.2 Consideration should be given to greater incentives for the implementation of the challenging new antenatal screening deadlines through primary care practice eg QoF.

4.3 Long term commitment should be given to guarantee the future development and maintenance of a managed clinical care network and centres of excellence for the treatment of sickle cell and thalassaemia. This will include ensuring commissioning and support processes including adequate payment by results coding and investment in training for relevant healthcare professionals.

January 2008

Memorandum by the Association of Public Health Observatories (APHO) (HI 87)

HEALTH INEQUALITIES

1. THE ASSOCIATION OF PUBLIC HEALTH OBSERVATORIES (APHO)

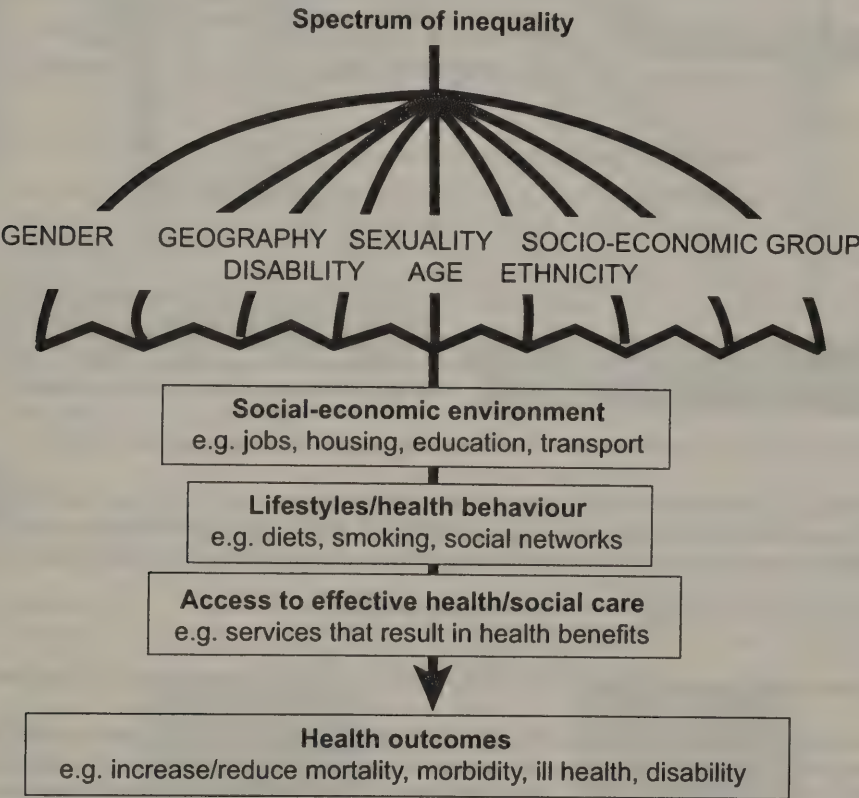
The LHO is one of a network of twelve Public Health Observatories (PHOs) that form APHO covering the United Kingdom and Ireland. APHO supports the PHOs in generating timely health intelligence to support decision-making at local, regional and national levels. We are part of the NHS family and work in partnership with practitioners, policy-makers and researchers on:

- Monitoring health, healthcare and disease trends and highlight areas for action;
- Identifying gaps in health information;
- Advising on methods for health and health inequality impact assessments;
- Drawing together information from different sources in new ways to improve health;
- Carrying out projects to highlight particular health issues;
- Evaluating progress by local agencies in improving health and reducing inequality; and
- Looking ahead to give early warning of future public health problems.

The London Health Observatory (LHO) is the national lead observatory on health inequalities, ethnicity and health and tobacco. For more information about the LHO and APHO see www.apho.org.uk and www.lho.nhs.uk.

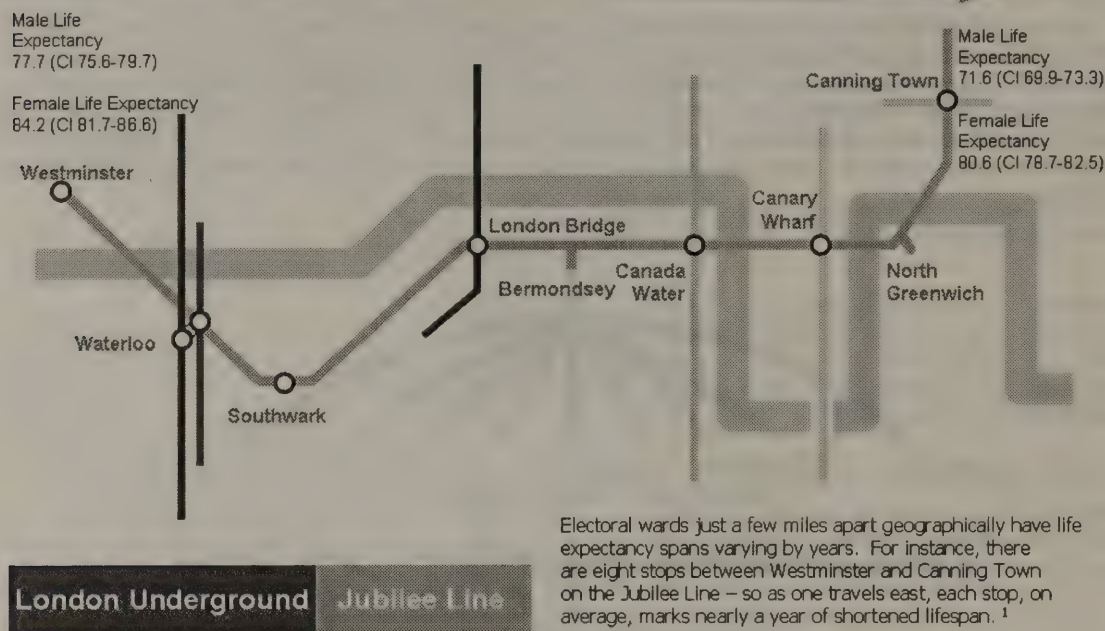
2. DEFINITION OF HEALTH INEQUALITIES

Any assessment of the role of the NHS in reducing health inequalities needs to start with a clear definition of what is meant by health inequalities, and which inequalities we are aiming to reduce. As in pathways of patient care, there is a pathway of causation throughout which inequalities can be reduced. For the major preventable causes of untimely death and disability such as cardiovascular disease (CHD and stroke), cancers, accidents and injury, tackling the “upstream” causes such employment, income and educational inequalities determines the speed and success of further “downstream” action by the NHS and its local partners.



Differences in Life Expectancy within a small area in London

Travelling east from Westminster, each tube stop represents nearly one year of life expectancy lost



¹ Source: Analysis by London Health Observatory using Office for National Statistics data. Diagram produced by Department of Health

The above diagram illustrates the many types of inequality (from causes to outcomes) and the dimensions of inequality (age, gender, geography ethnicity etc) that could be addressed. The diagram below illustrates how geographical inequalities can be clearly defined, but does not define ethnic or other types of inequality.

3. THE GOVERNMENT'S CURRENT OBJECTIVES TO REDUCE INEQUALITIES AND THE ROLE OF THE NHS

The current, overarching cross-government PSA is defined in terms of reducing geographical inequalities in life expectancy within which reducing socioeconomic inequalities in infant mortality are a part. This has shifted the focus to "levelling up" the 70 "Spearhead Local authorities" and 62 Primary care trusts (PCTs) which are in the worst fifth of deprivation and health indices in England. The importance of having a clearly defined national target cannot be overemphasised. Prior to this there was no clarity, no focus and no means of monitoring national progress. However the NHS and its partners have a span of influence that is primarily local. Given the key role of central government in catalysing speedier local action, we recommend that local target-setting on health inequalities is left to local partnerships—primarily through the LAA process and that national targets continue to be set and monitored through national, evidence—based policy making. This would be in keeping with devolution and the current limitations on the evidence base.

4. WILL THE GOVERNMENT MEET ITS CURRENT PSA TARGETS?

Projections for 2010 at a national level have shown that inequalities in life expectancy are set to widen and inequalities in infant mortality showing some evidence of narrowing
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081327

The secretary of State for health has announced a review of the strategy for reducing health inequalities which will provide a timely opportunity for setting longer term objectives based on the evidence to date. Two learning points emerge:

- The time needed to reduce inequalities in health outcomes is of the order of decades. It is thus vital to be able to identify both national and local evidence-based action in the short and medium term. It is the action that needs to be monitored alongside the outcomes.

- Local Progress in tackling inequalities has been shown to be unequal too and we submit the example of the “London Health Inequalities Forecast”
<http://www.lho.org.uk/viewResource.aspx?id=11106>
where inequalities in health are great and persistent. Only one spearhead authority/Primary care trust (PCT) in London is on track to meet the 2010 targets for life expectancy and cardiovascular disease and cancers. In the case of infant deaths, we submit our report “Born Equal?”
<http://www.lho.org.uk/viewResource.aspx?id=12371>
showing that national targets are difficult to monitor locally but a focus on known effective interventions in maternity care can identify areas for action across ethnic as well as geographical dimensions.

This evidence reinforces the need to separate what the NHS and partners can do locally out from what national government can achieve by population—wide legislation and fiscal policy.

5. HOW CAN THE NHS MAKE A COST EFFECTIVE CONTRIBUTION TO REDUCING HEALTH INEQUALITIES?

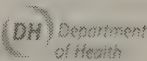
A local approach to cost-effective action needs to address the following questions:

(i) What are the causes of the Life expectancy gap in my Local authority/PCT?

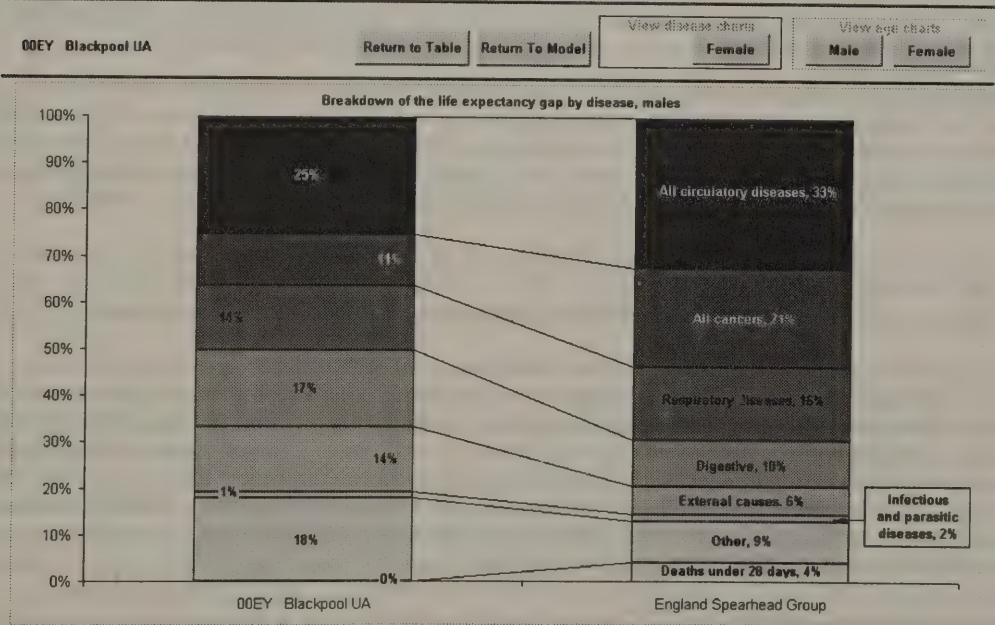
Whilst it is widely known that cardiovascular disease, cancers—mostly driven by smoking—explain the largest differences in the national gap in life expectancy, work by the Association of PHOs (APHO) has shown that the causes of the gap differ in different parts of the country. The London Health Observatory (LHO), and Yorkshire and Humber PHO (YHPHO) on behalf of APHO, have develop an easy to use, on-line “Health Inequalities Intervention Tool” that works out the size and causes of the gap in life expectancy for each Spearhead Authority. The diagram below shows the significant differences in the causes of the gap between Blackpool for example (where alcohol-related digestive causes are important) and Southwark (where infant mortality causes a major part of the gap). The tool can be accessed from the LHO website’s home page (www.lho.nhs.uk)



Working in partnership with the Department of Health

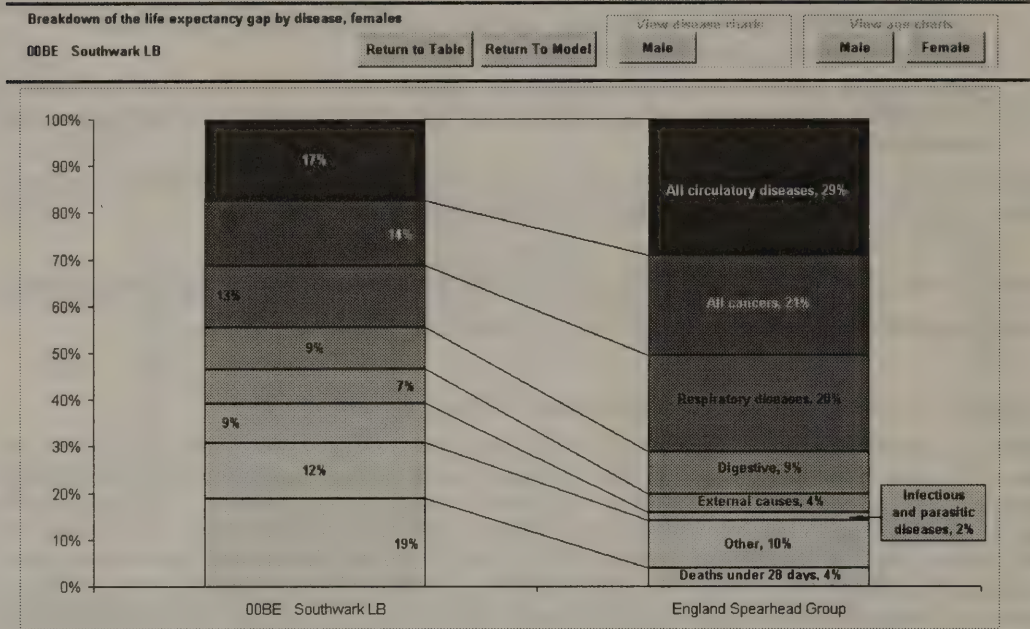


Health Inequalities Intervention Tool: View Your Gap





Health Inequalities Intervention Tool: View Your Gap



(ii) Which interventions are cost-effective and what impact might they have on my local gap?

The APHO online tool has a built-in interactive facility that helps users to plan the impact of four different, evidence-based interventions (smoking cessation, high blood pressure reduction and blood cholesterol reduction and infant mortality reduction) on closing the life expectancy gap.

Given the need for all parts of the country to tackle inequalities within their local authority areas, APHO is now developing a sister inequalities intervention tool to help plan the impact of evidence based interventions between small areas within local authorities. This will be ready to use in Spring 2008. The focus for the tool has been on interventions where this is good evidence of cost-effectiveness in community/primary settings. Other evidence will be built on the future public health programme at NICE.

(iii) Use the commissioning cycle to shift or invest in preventive care where it is most needed

World Class Commissioning expect the local NHS and local authorities to agree joint priorities through the Joint Strategic Needs Assessment Process and that inequalities where identified, can be prioritised. APHO is developing a intelligence resource to support the JSNA process. The use of the new resource allocation formula and the pace of change agreed within it will have a major effect on the ability of the spearhead authorities to “catch up” with the England average. Given the limited local span of the NHS, the potentially most important opportunities for reducing the inequalities gap in a cost-effective manner lie within primary care prevention with individuals in the short term and joint work with the local authority and education partners with whole schools in the long term.

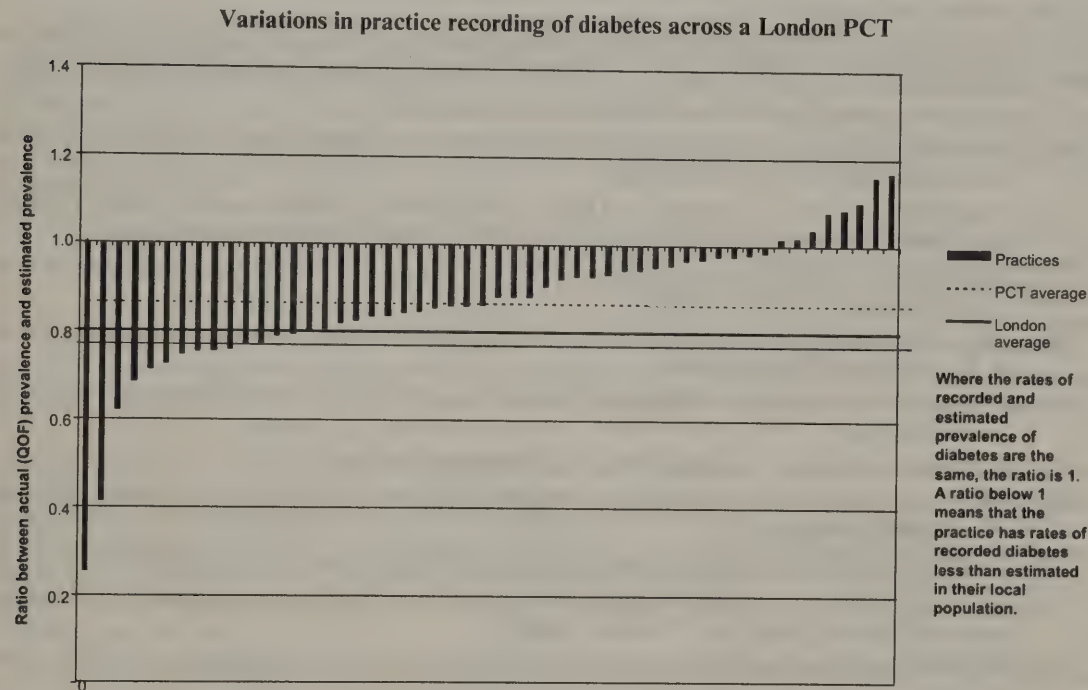
(iv) Monitor progress

The PHOs work together to support local and regional agencies to monitor the implementation of policy. This work has been hampered by a serious lack of local authority-level data on key lifestyle issues. Current Local Data on smoking-the biggest proximal cause of health inequalities—along with diet and alcohol is not available for monitoring. It is unacceptable to expect the local NHS to rely on estimates alone. Local data on childhood height and weight has not yet been released to PHOs and is long overdue.

We recommend that PHOs rapidly are designated as the main regional, safe repository of data on lifestyle as it is collected.

6. THE IMPACT OF PRACTICE-BASED COMMISSIONING AND THE USE OF QOF DATA.

The impact of practice-based commissioning on reducing health inequalities is currently unknown and needs proper evaluation. In terms of the current evidence it is likely that it is primary care commissioning that is likely to have the largest impact. Essential for this is a good understanding of the performance of all practices within a spearhead PCT. The Quality and Outcomes Framework (QOF) enables a start to be made, in areas of primary care where cost-effective interventions are important. The QOF system was not designed for monitoring population health—even at practice level—and needs to be interpreted with care. Eastern region PHO has provided helpful briefings on how to interpret QOF data. APHO has helped the process of interpreting the quality of patient care in areas where inequalities can be great by providing PCTs with estimates of the actual vs expected prevalence of diabetes—an important risk for CHD. The example below of practices within one London PCT shows which practices are failing to identify their expected diabetic patients and helps identify where support is needed. But it also shows that QOF data on its own is wide open to misinterpretation and does not record other key dimensions of inequality e.g. ethnicity, in any complete manner.



The illustration above shows that in order for the whole PCT to level up and reduce its inequality gap, all poorly performing practices will need to do better. The National support team has identified this need for what it calls the “Industrialisation” of good practice in spearhead PCTs.

7. WHAT IMPACT HAVE SPECIFIC INITIATIVES HAD AND IS THERE EVIDENCE OF INEQUALITIES WIDENING AS A RESULT OF NHS ACTION?

Research evaluations of major initiatives such as Sure Start, regeneration programmes and the health action zones have been described by some as having a disappointing impact on health inequalities. But it is important to recognise that local initiatives form only one small part of an overall programme of national, local and individual action. There is evidence to show that tobacco control initiatives have only gained momentum over many years when government as well as the local NHS and partners have acted in concert. This is not yet the case for many other causes of inequality such as obesity and alcohol.

Whilst the Acheson report on health inequalities cited strong evidence for both an inverse care and inverse prevention law operating in primary care, it is also clear that when inequalities are properly defined and resources properly re-directed to areas of greatest need, that parts of the inequalities pathway gap can be closed. This is true for the NHS smoking cessation service which has been shown by the Healthcare Commission and by independent research to be both clearly targeted to the most deprived areas, but also having its biggest impact in these areas.⁶⁷² The fact that the contribution of the NHS cessation service to

⁶⁷² J Chesterman, K Judge, L Bauld & J Ferguson, ‘How effective are the English smoking treatment services in reaching disadvantaged smokers?’ *Addiction*, volume 100, supplement 2 (April 2005), 36–45.

overall tobacco reduction in a community is small compared perhaps with the potential impacts of the smoke free legislation reinforce the point that policies and practice need to be developed both by central government and by the NHS and its partners to be able to show a significant impact.

January 2008

Memorandum submitted by Rethink (HI 88)

EXECUTIVE SUMMARY

1. Rethink's submission to the Committee focuses on inequalities experienced by people with severe mental illness.
2. People with severe mental illness die 10 years younger due to poor physical health healthcare and have higher than average rates of conditions including diabetes, coronary heart disease, stroke, respiratory disease and some forms of cancer.
3. The health inequalities agenda has moved on from geographical inequalities to social inequalities in health. The next step is to recognise health inequalities experienced by other groups and address barriers.
4. The issues set out here support the following recommendations:
 - (a) Non-social predictors of health inequalities, such as existing health condition, should be used to target those most at risk for screening.
 - (b) The NHS cannot measure inequality of health outcomes unless data for specific disability groups is collated. This should be a basic requirement for true analysis of health inequalities.
 - (c) Quality and Outcomes Framework funding formula should not disadvantage communities with high prevalence of chronic illnesses.
 - (d) Some check of quality of practice under the Quality and Outcomes Framework is needed as delivery is not guarantee of good practice.
 - (e) GP staff should be trained in mental health in order to provide a good service and avoid "diagnostic overshadowing".
 - (f) NHS must employ good practice in sharing information with carers.
 - (g) NHS needs to address implementation of recommendations made to Trusts and service through complaints and inquests.
 - (h) Health promotion should also be targeted as generic messages are not always effective.
 - (i) Health and social care services should be more joined up to be able to provide an individual care package to mental health service users and carers.
 - (j) The NHS should be leading good practice in supporting staff and volunteers with mental health problems.
 - (k) Changes to Department of Health policy must take into account the practical implications for individuals, as highlighted by expert stakeholders.

INTRODUCTION

5. Rethink, the leading national mental health membership charity, works to help everyone affected by severe mental illness recover a better quality of life. We were founded over 30 years ago to give a voice to people affected by severe mental illness and today, with over 7,800 members, we remain determined that this voice will continue to be heard. We help over 48,000 people every year through our services, support groups and by providing information on mental health problems. Our website receives almost 300,000 visitors every year.

6. Our knowledge of health inequalities comes from cases dealt with by our National Advice Service, our 8,000 members and our services. Our National Advice Service reports an increase in the number of cases of health inequalities.

7. At least, 630,000 people have a severe mental illness in England. People with major mental health problems are more likely than other citizens to develop particular significant health problems, and to develop them at a younger age.

- 31% of people with schizophrenia and Coronary Heart Disease (CHD) are diagnosed under the age of 55, compared with 18% of general population.
- 41% of those with schizophrenia are diagnosed with diabetes under the age of 55, compared with 30% of others with diabetes.
- 21% of those with schizophrenia who have a stroke are under 55, compared with 11% of others who have a stroke.

- 23% of those with schizophrenia and respiratory disease are diagnosed under the age of 55, compared with 17% of others with respiratory disease.⁶⁷³

People with severe mental illness are also likely, once they have developed physical health problems, to die more quickly than other citizens.

The distribution and quality of GP services and their influence on health inequalities, including how the Quality and Outcomes Framework and Practice-based Commissioning might be used to improve the quality and distribution of GP services to reduce health inequalities.

8. The inclusion of annual health checks for people with severe mental illness in the QOF is an important and welcome step forward. However, we now need to ensure that these checks are of the quality required. Our concern with the Quality and Outcome Framework approach is that “outcomes” are not measured according to the final outcome of the patient. The quality of delivery of the services offered under this framework is not measured. We have had feedback that health checks may take only 10 minutes, with the result that emerging health problems are missed.

9. Rethink has dealt with many cases, and often receives information from members, regarding discrimination against patients with mental illness. There is a clear tendency for their health concerns to be dismissed as manifestations of their mental ill health, a practice known as “diagnostic overshadowing”. This is absolutely unacceptable. Mental illness does not mean that a patient is not intelligent or informed. This kind of discrimination can have tragic consequences for some, but can lead to serious inequality in health and access to services for many. Service users consistently identify stigma as an impediment to their overall health and well-being⁶⁷⁴ and access to services⁶⁷⁵.

9.1 “On one occasion I could tell my GP was dismissing my concerns about having developed stomach pain. When I told him I was worried that I might have a stomach ulcer. He appeared to think I was being a hypochondriac. It eventually transpired that an antibiotic he had prescribed had reacted badly with my medication and caused acute stomach pain. On another occasion I’d been referred by my GP to an orthopaedic surgeon because of long-standing complaints about excruciating sciatic pain. I saw the confidential letter he wrote to the consultant. In it explained that he was only really referring me because he thought I might ‘have a breakdown’ if I wasn’t referred for treatment, the implication being it was ‘all in my head’.”

10. An important GP quality issue is that of competence in dealing with mental health. Rethink is aware of GPs who may have had only 1 day of training provided, despite the fact that 1 in 4 people with experience mental health or behavioural problems at some time in their life. This leads to some of the most crucial issues in health inequality for those with a mental health diagnosis. We would like to see improved staff training, explicitly to reduce the risk of “diagnostic overshadowing”, Clinicians need to be encouraged to have a greater level of suspicion about physical ill health in someone with severe mental illness.⁶⁷⁶ One of our members reports that:

10.1 “I am still conscious of being treated first and foremost as a mental health patient, rather than just a patient. This worries me, as I feel they give less attention to my physical needs than they would otherwise. For example, I suffer from asthma/and or chronic obstructive airways condition. My surgery has an asthma clinic, and yet I am not asked to attend.”

10.2 “When I first registered they treated me as a worthwhile human being, a credible carer who they had had contact with many times over the years due to my caring role for both my parents. Then, without doubt, as soon as they were in receipt of my “fat” psychiatric notes, everything changed. I think they are scared of dealing with me & I always feel unwelcome. I am patronised, they don’t want to know what I think about my problems or treatment. I am treated as if I making an unnecessary fuss, as if I too demanding, they dismiss my many physical health problems instead of offering investigation or reassurance & have sent me away feeling like a worthless nuisance. I have felt suicidal many times recently but I would not pitch up at that practice if they were the last place on earth. I really do believe it will be as a result of me not having the comfort of a good relationship with my GP & feeling unable to pitch up to see them during times of crisis that ultimately I do not feel able to continue my life.”

11. Unlike other QOF registers, people with severe mental illness have to consent to be on a “register”, without requiring primary care practitioners to provide full information or reassurance about the nature and purpose of these checks. This means that those who are most ill and perhaps most paranoid and worried by the health care system are least likely to give consent and participate, a perverse outcome. We have heard of some areas of good practice, with practices organising face-to-face meetings with patients with severe mental illness to explain the health checks. In 2004, Rethink, together with the National Institute for Mental Health in England, produced a leaflet entitled “Getting more from your GP practice”. 200 000 copies of this

⁶⁷³ Disability Rights Commission (2006) *Equal Treatment: Closing the Gap*.

⁶⁷⁴ Mental Health Foundation (2000) *Strategies for Living*.

⁶⁷⁵ ODPM (2004) *Mental Health and Social Exclusion*, HMSO.

⁶⁷⁶ Disability Rights Commission (2006) *Equal Treatment: Closing the Gap*.

leaflet were produced in summer 2004. More initiatives like this to inform people of the value of attending a health check and allay the fears of both people with severe mental illness and carers are needed. The QOF should allocate extra points to promotion of the health check among the target group.

12. We are encouraged that the QOF was amended in the most recent GP contract to include lifestyle advice within health checks for people with severe mental illness. Up until then, there was evidence that GPs were unlikely to give “lifestyle” advice to people with mental illness.⁶⁷⁷ Rethink is encouraged that the QOF review team took evidence from Rethink about this need and acted upon it.

13. The QOF needs to be further updated to include within the annual health check should a glucose intolerance test for everyone with severe mental illness. Diabetes is a growing problem in the Western world, which is associated with obesity and early death. Rates of diabetes are up to 5 times higher among people with severe mental illness than in the general population and contribute to people with severe mental illness dying 10 years younger than others due to physical health problems. Diabetes is highly prevalent among people with schizophrenia, but most remain undiagnosed in the community. (Holt, *Journal of Psychopharmacology* 2005; 19(6) Supplement 56–65), with prevalence at least 2–3 times that of the background population (Lamberti *et al.*, Prevalence of diabetes mellitus among outpatients with severe mental disorders receiving atypical antipsychotic drugs, *Journal of Clinical Psychiatry* 2004 May;65(5):702–6;). People who take psychiatric medication can experience diabetes even where they have a low mean BMI (Emsley R, Turner HJ, Schronen J, Botha K, Smit R, Oosthuizen PP: Effects of quetiapine and haloperidol on body mass index and glycaemic control: a long-term, randomized, controlled trial. *Int J Neuropsychopharmacol* 8:175–182, 2005), hence people with schizophrenia should be screened for diabetes regardless of BMI, sometimes used as a predictor of diabetes in the background population. There seems to be a particular association with clozapine (Lund BC, Perry PJ, Brooks JM *et al* Clozapine use in patients with schizophrenia and the risk of diabetes, hyperlipidemia and hypertension: a claims based approach, *Arch Gen Psychiatry* 2003; Gianfrancesco FD *et al* Differential effects of risperidone, olanzapine, clozapine and conventional antipsychotics on type 2 diabetes: findings from a large health plan database. *Journal of Clinical Psychiatry* 2003; 63: 920–930) and olanzapine (Wirshing D A, Spellberg BJ *et al* Novel antipsychotics and new onset diabetes, *Biological Psychiatry*, 1998; 44: 778–783(6)).

NICE recommends that primary care professionals regularly monitor physical health (National Institute for Clinical Excellence, Schizophrenia full national clinical guideline on core interventions in primary and secondary care, Gaskell and British Psychological Society 2003; 97, 146). Yet the health needs of people with learning disabilities and/or mental health problems are often “off-loaded” onto specialist services rather than addressed through regular primary care (Samele C, Seymour L, Morris B, Central England People First, Cohen A and Emerson E, A formal investigation into health inequalities experienced by people with learning difficulties and/or people with mental health problems 2006, Area Studies report).

14. Access to treatment and services is also regularly denied when carers or relatives seek help on behalf of someone with mental illness. Rethink carried out research with SDO to develop policy guidance⁶⁷⁸ on this issue, which would be useful for GP practice. As part of this SDO project work, a survey of 214 mental health carers was carried out. 44% of mental health carers said that “confidentiality” has been cited as a reason that health professionals cannot share information with the carer. Where carers ask professionals to provide better physical healthcare or report a physical health problem, this should be taken seriously. Misuse of confidentiality can have serious consequences:

- 16% of carers are not being involved or listened to where their involvement could have made a difference in terms of outcomes for the service user.
- 14% said the person they care for had been affected through delayed access to help or loss of social support.
- 12% of carers said that the person they care for had been discharged from hospital without the carer’s knowledge or support.

Carers can have an important role in ensuring that people with severe mental illness access physical health services and report physical health needs. Yet, 31% of carers lack the information and knowledge they need to support them in their caring role.

15. The point about discharge without informing family is particularly worrying as this can leave the patient highly vulnerable. This is a Trust rather than a GP service quality issue, but we believe that this is a key issue for health inequalities as highlighted by the tragic case of Steven Hart:

Steven’s condition remained deeply disturbed for the whole of 25 September, but by the following day he appeared to have stabilised, and sought to discharge himself. No transport could be arranged immediately and Steven chose to leave, though he asked a nurse to show him the way out as he could not read the signs to the hospital exit and could not remember his admission. He was discharged at 12.30pm, with no money, no transport and without his family being informed. Thereafter a total of four 999 calls were made by members of the public who observed Steven’s strange behaviour, lost and vulnerable, wandering apparently in circles trying to find a road home. Calls around 8pm, by which time it was dark, led to a police officer giving Steven a lift to the A61

⁶⁷⁷ Hafal/MDF/Primhe/RCN/SANE (2005) *Running on Empty*.

⁶⁷⁸ SDO Department of Health (2006) Sharing mental health information with carers: pointers to good practice for service providers.

road to Ripon and Harrogate at its intersection with the A1. Steven set off again on foot but was observed some twelve minutes later retracing his steps over the A1 once more, and within a further four minutes observed on the A1 itself by a concerned motorist who rang 999, walking southbound down the fast lane of the northbound carriageway. Less than an hour later, having removed his clothes, he was run over in a similar position and killed.—Inquest Press Release, 15th October 2007.

16. Inquest and complaint investigations do at times result in clear recommendations being made to the NHS Trust or service. There is, however, no duty on Trusts or services to implement these recommendations, despite the resource invested in finding systemic failures. This should be a basic requirement—to address specific practices which would likely protect others from the same risks to their health and wellbeing in the future. In one case investigated by the Healthcare Commission, a young man with severe mental illness was being treated with clozapine. People using this medication should be given regular blood tests as there is a strong association between clozapine use and diabetes.⁶⁷⁹ Blood tests were not offered until the mother of the man intervened and made multiple requests to the Trust in question. By the time this was done, the young man had already developed diabetes. When the Healthcare Commission investigated, it found that the clozapine clinic which should have been running to carry out these tests was, in fact, not running. A year later, when the mother asked staff at the Trust about what had happened as a result of the Healthcare Commission investigation, staff had no knowledge of the recommendations about clozapine clinics and nothing had actually changed.

17. There are clear relationships between social disadvantage (poverty, unemployment, BME, poor housing, social exclusion etc.) and severe mental illness. It is essential that GPs serving areas with high incidence of these issues are properly resourced. We share the concerns of the NHS Confederation that the Quality and Outcomes Framework formula disadvantages GP surgeries with high prevalence of particular conditions.

The effectiveness of public health services at reducing inequalities by targeting key causes such as smoking and obesity, including whether some public health interventions may lead to increases in health inequalities; and which interventions are most cost-effective;

18. Health inequalities are not determined by social demographic alone, and should not ideally be measured in terms of geographical comparison. There are in fact health factors which can predict further health inequality, such as mental illness.

19. Inequality of health is a major issue for people with mental illness. The 2006 Disability Rights Commission report on health inequality⁶⁸⁰ cites evidence that people with major mental health problems are more likely than other citizens to develop particular significant health problems, and to develop them at a younger age.

20. We are disappointed that the NHS did not heed the advice of the Disability Rights Commission on measuring health outcomes by disability to counter these inequalities. It is essential to be able to identify groups at particular risk to health inequalities, and consider taking measures to do so as a basic necessity.

21. Predictors of health inequalities, such as mental illness diagnosis, should be made use of through screening vulnerable groups. There is a higher incidence of smoking, obesity, diabetes, stroke, CHD, respiratory problems and some form of cancer in people with mental illness. We emphasise the importance of the routine screening of this group to identify health problems as early as possible.

22. Rethink has developed a Physical Health Check tool for a range of health professionals to screen for physical health problems. This is a simple and cost effective method to prevent health inequalities, improve quality of life and life expectancy of this group. It can be used in a variety of settings by different professionals, eg in prisons, in community mental health services, in inpatient wards. Such remedies are essential to counter the lack of knowledge of many mental health professionals about physical healthcare and ensure that referral to specialist physical health professionals for treatment.

23. It is also important to consider targeting key audiences in health promotion. Evidence suggests that general health promotion campaigns are not effective for people with mental illness—they do not respond because they feel that they are “not for us”⁶⁸¹.

⁶⁷⁹ (Lund BC, Perry PJ, Brooks JM *et al* Clozapine use in patients with schizophrenia and the risk of diabetes, hyperlipidemia and hypertension: a claims based approach, *Arch Gen Psychiatry* 2003.

⁶⁸⁰ Disability Rights Commission (2006) *Equal Treatment: Closing the Gap*.

⁶⁸¹ Friedli L, Dardis C, Not all in the mind: Mental health service user perspectives on physical health, *Journal of Mental Health Promotion* 2002;1: 36–46.

The success of NHS organisations at co-ordinating activities with other organisations, for example local authorities, education and housing providers, to tackle inequalities; and what incentives can be provided to ensure these organisations improve care

24. Co-ordinated support is essential for people with mental health problems, and the NHS should be looking at joining up more effectively with local authorities. It is essential for health services to play some role in encouraging and supporting people with mental health problems into appropriate work. We are encouraged to hear that there are plans to start employment services into GP surgeries. This is particularly important for people who are not in contact with secondary mental health services, and may be seeing only their GP for regular treatment.

25. The NHS should also be developing links with the Department of Work and Pensions departments: Disability & Carers Services and JobCentre Plus. Increased knowledge of the processes around benefit claiming, especially those relating to medical assessment and exemptions from this, would be highly beneficial. The onus is often on the individual to ensure that information is shared effectively between health professionals and DWP, which means that those who are ill at the time are the most vulnerable.

26. Carers of people with severe mental illness can also experience health inequalities. 1 in 4 mental health carers provide more than 50 hours per week care, and this, combined with emotional stress, can have a significant impact on their mental and physical health.⁶⁸² It is essential that health service identify carers and refer them for their own needs assessments by local authorities and to local services, such as respite care.

The effectiveness of the Department of Health in co-ordinating policy with other government departments, in order to meet its Public Service Agreement targets for reducing inequalities

27. The Department of Work and Pensions aims to move those who are able off benefits and into work through the Pathways to Work programme. There is also a PSA (16) to increase the number of people with mental illness in employment. One of the greatest barriers to employment is not unwillingness on the part of the individual, but stigma and discrimination and a lack of understanding on the part of employers. Unfortunately, the NHS perpetuates this stigma through inconsistent practice in employing paid workers and volunteers with mental health problems.

28. Rethink has received reports of people with mental illness being told they pose too great a risk to work within the NHS, based on their diagnosis alone, with no attempt made to support them in the role.

“As I have applied to become a volunteer at four different NHS hospitals and all four declined to take me on—first they accepted me, but as soon as I informed them I had a mental health difficulty—straight away they decided not to take me on. They claimed I posed a threat to the public—because of my mental health difficulties. Though I have never committed any crimes or acts of violence against anyone, they used my mental health difficulties against me. I can’t believe that NHS hospitals responsible for protecting patients would deliberately go out of their way to discriminate against mental health patients.”

29. The NHS is one of the largest employers in the UK, and should be leading the way in good practice for developing opportunities for work and volunteering for socially excluded people. In fact, as a public body, the NHS should be adhering to Disability Equality Duty, which obliges them to develop plans to address issues such as this, and to evaluate progress. These top level policies must then translate into local practice through staff training.

30. Rethink is particularly concerned by the development of the plans to abolish standard level Care Programme Approach (CPA). The consultation process for this was poor—with limited information shared with stakeholders, and a disregard for expert views.

31. There has been an apparent disregard also for the impact of removing standard CPA on related policy, especially where CPA is cited as criteria for eligibility for a service or identification of a group targeted by government spending. People with severe mental illness have been identified specifically for the first time in the recent Comprehensive Spending Review and we are concerned that people losing standard CPA will not be counted amongst this group. It was also not made clear whether people being removed from CPA will now be under the care of their GP, and what is being done to support or resource GPs to do this.

32. We are highly concerned that loss of standard CPA will result in more “missing people”.. Already, about 50,000 people with severe mental illness are living in the community without any specialist support.⁶⁸³ For people with mental illness, this could mean more people finding themselves part of this “Forgotten Generation”. They may be medically stable under care of their GP, but losing CPA may mean access to social care and support and further social exclusion. This group are sometimes referred to as being “seldom heard”, but we would argue they are seldom listened to.

January 2008

⁶⁸² *Under Pressure*, 2003, Rethink.

⁶⁸³ *Lost and Found*, Rethink 2004.

Memorandum by the National Heart Forum (HI 89)

HEALTH INEQUALITIES

1. INTRODUCTION

1.1 The National Heart Forum (NHF) is the leading alliance of over 50 national organisations working to reduce the risk of chronic disease in the UK. Member organisations represent the medical and health services, professional bodies, consumer groups and voluntary organisations. This submission does not necessarily represent the views of all of our member organisations.

1.2 Ten years after the publication of the Acheson Report⁶⁸⁴, health inequalities still represent a significant if not greater challenge. Among men life expectancy at age 65 is currently 4 years higher for those in social class I than social class V, while the gap among women has widened significantly over the past 20 years⁶⁸⁵. These differences are even more pronounced when geographical variations are taken into account. Although mortality rates for cardiovascular disease have been decreasing at both ends of the social scale, they have been decreasing much more quickly among upper socio-economic groups and this difference has made a large contribution to the widening of inequalities in mortality. Improved standards of living and health care have improved everyone's chances of living longer but the least well off have gained least⁶⁸⁶. This will be reiterated in a forthcoming publication on inequalities in cardiovascular disease to be published by the BHF Health Promotion Research Group at University of Oxford⁶⁸⁷.

1.3 The NHF believes that the need to tackle health inequalities should be an intrinsic part of any public health strategy. Unfortunately public health has borne the brunt of many of the changes and financial crisis within the NHS in recent years. In order to meet the challenge of tackling health inequalities, the NHF makes the following recommendations

1.4 The Government should invest in an independent, credible and authoritative public health system to help fully engage the public, positively alter the health culture and encourage healthy lifestyles in England.

1.5 The Government should establish a National Institute for Public Health in England focusing on non-communicable diseases to complement the work of the Health Protection Agency. It should be accountable to the CMO for England and work across Government.

1.6 The Government should introduce a new Public Health Act to provide the legal powers and duties of the state to create the conditions to enable the people to be healthy—to identify, prevent and ameliorate risks to health in the population. It should also challenge the current limitation to the power of the state to constrain the autonomy, privacy, liberty, property or other legally protected interests of individuals for the protection or promotion of community health⁶⁸⁸. These duties should include the requirement to carry out an independent health impact assessment on all policies in a similar manner to the current requirement to carry out a Regulatory Impact Assessment.

1.7 The NHF believes that there is an increasing need for the government to address these commercial determinants of health if it is to avoid seeing a further increase in health inequalities.

1.8 The NHF also supports the comments and recommendations on Tobacco control made by ASH and the Faculty of Public Health in their submissions to the Health Select Committee enquiry.

2. THE EXTENT TO WHICH THE NHS CAN CONTRIBUTE TO REDUCING HEALTH INEQUALITIES, GIVEN THAT MANY OF THE CAUSES OF INEQUALITIES RELATE TO OTHER POLICY AREAS EG TAXATION, EMPLOYMENT, HOUSING, EDUCATION AND LOCAL GOVERNMENT;

2.1 The NHF believes that the NHS can clearly contribute to reducing health inequalities. Examples include undertaking screening as announced recently by the Prime Minister⁶⁸⁹ (however if this is carried out on a voluntary basis it may exacerbate inequalities) or as a facilitator in joining up working across public health and local government agendas and in managing joint working toward inequalities targets. However the NHF is concerned that a continuing emphasis on area-based interventions characterized by the current Spearhead initiatives is a consequence of political rather than evidence-based necessity and will fail to reach the majority of those in need of help. The current emphasis on Spearhead areas will inevitably—as with all area-based initiatives—fail to reach the majority of those in the lowest socio economic groups.

⁶⁸⁴ Acheson D (1998) Independent inquiry into inequalities in health London: Stationery office.

⁶⁸⁵ Donkin *et al* (2002) ONS Longitudinal Study 1977–1999, England and Wales.

⁶⁸⁶ Mackenbach JP *et al* (2003) Widening socioeconomic inequalities in mortality in six Western European Countries in *International Journal of Epidemiology* 32, pp 830–837.

⁶⁸⁷ BHF Health Promotion Research Group at University of Oxford Regional and Social Differences in Coronary Heart Disease Forthcoming.

⁶⁸⁸ Gostin L (2004) Health of the People the Highest Law. Conference proceedings, Nuffield Trust, London.

⁶⁸⁹ Prime Minister statement reported on BBC website http://news.bbc.co.uk/1/hi/uk_politics/7174340.stm 07.0108.

2.2 The potential role of the NHS to tackle health inequalities is clearly impaired by the impact that “wider determinants” such as taxation, employment, housing, education and local government play on health as characterised in the Department of Health’s own Health Inequalities Programme for Action⁶⁹⁰. Recent Public Health policy has been characterized by the notion of health as a matter of choice⁶⁹¹, in some respects as a limited interpretation of Wanless’s “Fully engaged scenario” set out in his two reports for HM Treasury⁶⁹², which as well as highlighting individual responsibility, also noted that corporations shape social norms as well as meet consumer demand. He argued that the private sector must move towards “full engagement” in public health (as well as the public and voluntary sectors) if the spiralling costs attributable to avoidable chronic disease are to be checked. This individual approach espoused in *Choosing Health* is in stark contrast to previous policy which focused more on improving material circumstances in order to improve health.

2.3 Whilst individuals clearly have a role to play in determining their own health, the NHF supports the notion championed in the recent Foresight report, *Tackling Obesities*⁶⁹³ which challenges the assumption that our health is predominantly a matter of our own choice and responsibility. In relation to obesity, it concludes that the evidence supports the concept of “passive obesity” (where obesity is encouraged by wider environmental conditions, irrespective of volition). Today, the majority of people in the UK are sedentary when at work and at home. Eating habits have become more unstructured, and low-cost, energy-dense “foods high in fat, sugar, salt and drink on the go” are widely consumed. For a multitude of reasons, healthy lifestyles may be less available to those on low incomes who are poor in terms of both time and money. Therefore, people do not “choose” to be obese. Their obesity is driven by a range of factors that constrain individual choice and are beyond their immediate control.

2.4 The NHF believes that in order to fully understand health inequalities we need to examine the broad environment including social, economic and cultural circumstances. There is a predominant culture in our society which is highly unequal, competitive, materialistic and individualistic. Evidence increasingly suggests that what might be termed the “commercial determinants of health” are having a prevailing negative impact on many of the risk factors which create health inequalities.

It should be noted that commercial organisations and their products do have the potential to have significant, positive public health effects. The creation of wealth and employment enables better standards of living and generally promotes health when employment policies and business practices are fairly and appropriately regulated. However, the extrinsic costs which arise from negative health impacts of business practices are borne by society, not industry and generally by those at the lower end of the social scale.

2.5 However, changes in the national diet towards energy-dense convenience foods, drinks and snacks are partly responsible for major public health epidemics of obesity, type 2 diabetes and hypertension. The food industry by its nature is continually battling to increase demand and sales and despite innovating products high in fat, sugar or salt and marketing them relentlessly to all ages, the industry is not subject to any controls or sanctions in the interest of public health, either as a precautionary principle or in line with a principle that the “polluter must pay”.

2.6 An illustration of how commercial interest can potentially exacerbate inequalities is the current duality of food labeling schemes currently adopted by both retailers and manufacturers.

2.7 A large scale quantitative study commissioned by the Food Standards Agency demonstrated firstly that all four signposting methods including a multiple traffic light (MTL) and Guideline Daily Amounts (GDA) not surprisingly, performed better than no signposting in helping consumers make health eating choices.

2.8 Secondly and significantly in relation to the health inequalities debate in individual product assessments, MTL performed best across all socio-economic groups including C2 (89% correct responses compared with 67% with GDA) and DE subgroups (89% compared with 65% with GDA). Among the main minority ethnic groups, MTL performed best in the individual product evaluation (93% correct responses against 66% for GDA)⁶⁹⁴. Despite, government support for the MTL scheme and consumer demand for a single scheme in the market, two of the four major supermarkets and most of the leading manufacturers have chosen to adopt the GDA scheme. The failure of these companies to fall in line with the government-preferred MTL scheme—which demonstrably works better with consumers in lower social groups—risks not only confusion for consumers, but widening dietary inequalities.

2.9 Given the current plateau in smoking rates coupled with increasing burdens of diet and alcohol related illness which are all greater for those in lower socio economic groups, there is an increasing need for the government to address these commercial determinants of health if it is to avoid seeing a further increase in health inequalities.

2.10 The NHF recommends that the government gives greater consideration to the commercial determinants of health particularly with respect to their impact on health inequalities.

⁶⁹⁰ Department of Health (2003) *Tackling health inequalities: A Programme for Action* London: DH.

⁶⁹¹ Department of Health (2004) *Choosing health: Making Healthier choices easier* London: DH.

⁶⁹² Wanless D (2002) *Securing our future health* & (2004) *Securing good health for the whole population* both London: HM Treasury.

⁶⁹³ Foresight tackling Obesities : *Future Choices* (2007) London: GOS.

⁶⁹⁴ <http://www.food.gov.uk/foodlabelling/signposting/signpostlabelresearch/> accessed 19th December 2007.

3. THE EFFECTIVENESS OF PUBLIC HEALTH SERVICES AT REDUCING INEQUALITIES BY TARGETING KEY CAUSES SUCH AS SMOKING AND OBESITY, INCLUDING WHETHER SOME PUBLIC HEALTH INTERVENTIONS MAY LEAD TO INCREASES IN HEALTH INEQUALITIES; AND WHICH INTERVENTIONS ARE MOST COST-EFFECTIVE

3.1 As previously noted evidence clearly demonstrates that the key lifestyle determinants of future health, smoking, diet and alcohol, all have a greater impact on those in lower socio economic groups. Smoking rates are higher amongst the lower socio economic groups who also show the greatest resistance to smoking cessation interventions. It has been suggested that much of the rise in life expectancy we have seen in recent years can be attributed to the fall in rates of smoking.⁶⁹⁵ According to the Office for National Statistics, the overall smoking rate bottomed out at its present level in 2001 and has remained stable ever since.

3.2 Obesity and its attendant illnesses are rising rapidly across all socio-economic groups. They are rising fastest amongst the lower classes as the less healthy energy dense foods high in fats, sugar and salts also tend to be the cheapest and the most heavily marketed. Similarly there are significant inequalities in physical activity rates in part as a consequence of the environment which those in low income are likely to live in. This would perhaps support a suggestion that we should reduce inequalities by targeting key causes such as smoking and obesity.

3.3 Whilst NHF support this type of approach, it also supports the comments and recommendations made by ASH and the Faculty of Public Health in their submissions to the Health Select Committee with respect to tobacco control.

3.4 However international examples demonstrate that it is not always the richest countries, rather the most egalitarian that have the best health, as our understanding of the impact of relative deprivation on our health increases. So perhaps in the longer term, the biggest impact on health inequalities will come from reducing social inequalities, this is outside the scope of public health services but within the remit of other Government departments, particularly the Treasury.

3.5 In addition NHF believes that The Government should invest in independent, credible and authoritative public health system to help fully engage the public, positively alter our health culture and encourage healthy lifestyles in England.

3.6 In order to achieve this, the Government needs to establish a National Institute for Public Health for England focusing on non communicable diseases to complement the work of the Health Protection Agency and be accountable to the CMO for England and work across Government.

3.7 In order to support these new structures the government needs to introduce a new public health act to provide the legal powers and duties of the state to assure the conditions for the people to be healthy-to identify, prevent and ameliorate risks to health in the population- and the limitation on the power of the state to constrain the autonomy, privacy, liberty, property or other legally protected interests of individuals for the protection or promotion of community health⁶⁹⁶. These should include the need to carry out a health impact assessment on all policies in a similar manner as currently exists in the requirement to carry out a Regulatory Impact Assessment.

4. WHETHER SPECIFIC INTERVENTIONS DESIGNED TO TACKLE HEALTH INEQUALITIES, SUCH AS SURE START AND HEALTH ACTION ZONES, HAVE PROVED EFFECTIVE AND COST-EFFECTIVE

4.1 One of the difficulties with area based interventions is that although it is possible to develop indices of deprivation for geographical areas it is unusual for the residents to be exclusively deprived, particularly given the gentrification of many traditional inner city deprived areas. There is some evidence that area based initiatives such as Sure Start and Health Action Zones are subject to the same inverse care law which affects other public services. In other words despite their best efforts to target those most in need they often support those with lesser needs.

4.2 It is difficult to determine whether interventions such as Health Action Zones were effective particularly as they were not given sufficient time to meet their aims before being disbanded. Whilst in many cases the projects may not have shown significant short term gains it is also true that many which have had initially promising results have been shown not to be sustainable beyond the short term.

5. THE SUCCESS OF NHS ORGANISATIONS AT CO-ORDINATING ACTIVITIES WITH OTHER ORGANISATIONS, FOR EXAMPLE LOCAL AUTHORITIES, EDUCATION AND HOUSING PROVIDERS, TO TACKLE INEQUALITIES; AND WHAT INCENTIVES CAN BE PROVIDED TO ENSURE THESE ORGANISATIONS IMPROVE CARE.

5.1 The Department of Health "Health Inequalities Programme for Action"⁶⁹⁷ clearly sets out those actions most likely to have the greatest impact in tackling inequalities in health. The role of the Director of Public Health in each PCT is crucial in joining up initiatives to tackle health inequalities. However, increasingly in recent years they have been inadequately resourced to carry out this role. When NHS budgets

⁶⁹⁵ Dr John Powles (Cambridge University) speaking at joint NHF/LSE/ RCP seminar 27th Feb 2006.

⁶⁹⁶ Gostin L (2004) Health of the People the Highest Law. Conference proceedings, Nuffield Trust, London.

⁶⁹⁷ <http://www.dh.gov.uk/en/Publichealth/Healthinequalities/ProgrammeforAction/index.htm>

are cut, it is always public health that, is disproportionately affected in order to minimise cuts to acute healthcare services. This is a short-sighted policy that works against the capacity of the NHS being able to reduce health inequalities, because of the longer timeframes involved.

5.2 Recent reforms of public health have resulted in a substantial loss of workforce capacity, with many of the most experienced and well-respected public health staff leaving the profession or at least leaving the NHS. Public health delivery requires continuity not reorganisation, so that workforce capacity at all levels can be built up. Stability is required not only for recruitment and retention but to enable local knowledge, relationships and trust to be built up to enable efficient and effective joint working across different types of organisations and providers.

6. THE EFFECTIVENESS OF THE DEPARTMENT OF HEALTH IN CO-ORDINATING POLICY WITH OTHER GOVERNMENT DEPARTMENTS, IN ORDER TO MEETS ITS PUBLIC SERVICE AGREEMENT TARGETS FOR REDUCING INEQUALITIES; AND

6.1 The Department of Health has developed significant resources and expertise in tackling health inequalities in recent years. The NHF welcomed the establishment of a Health Inequalities Unit within the Department.

However, coordinating policy across government departments has always proved difficult, other government departments are driven by their own PSA targets. This is the by product of a target-driven policy agenda. Until all departments are aware of and act upon their ability to influence these determinants of health, the Department of Health will continue to be regarded as the Department of the NHS—a curative rather than a National Disease service.

6.2 Virtually all Government programmes have the potential to narrow health inequalities or, indeed, to widen them. Therefore to be truly effective, it is essential that the DH works together in co-delivery mode with local government. The Government is encouraging and supporting local authorities to improve the health of their communities and to tackle health inequalities. Local authorities working in effective partnership with the NHS, other public sector bodies and the private, voluntary and community sectors is crucial to tackling the health problems in their areas.

7. WHETHER THE GOVERNMENT IS LIKELY TO MEET ITS PUBLIC SERVICE AGREEMENT TARGETS IN RESPECT OF HEALTH INEQUALITIES.

7.1 While the Government persists with an individual-focus to health and inequalities, there will be difficulties in meeting targets. Perhaps we should be focused on sticking to targets which have been subject to a number of alterations in their spatial and social units and timings. Neither, the target for local authorities or that for infant mortality set out below are true health inequalities targets because they compare the worst off groups with the average of the population as a whole rather than considering the entire distribution.

- Starting with children under one year, by 2010 to reduce by at least 10 per cent the gap in mortality between routine and manual groups and the population as a whole.
- Starting with local authorities, by 2010 to reduce by at least 10 per cent the gap in life expectancy between the fifth of areas with the worst health and deprivation indicators (the Spearhead Group) and the population as a whole.⁶⁹⁸

January 2008

Memorandum by the CBI (HI 90)

HEALTH INEQUALITIES

1. As the UK's leading business organisation, the CBI speaks for some 240,000 businesses that together employ around a third of the private sector workforce, covering the full spectrum of business interests both by sector and by size. Business has a triple stake in the delivery of an effective health service, as users, funders and increasingly providers of health services. Healthy employees are needed to help businesses compete in the global marketplace; companies generate 27% of yearly tax revenues—some of which is used to pay for the NHS; and many businesses are now directly involved in health provision, including primary care services.

2. The CBI believes social equity should be one of the main goals of public service reform, with public service providers from all sectors working together to help achieve it. Health inequalities—for example those to do with age, access, disability or the particular needs of hard-to-reach groups—not only damage social cohesion but also the UK economy.

⁶⁹⁸ http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Healthinequalities/Healthinequalitiesguidancepublications/DH_064183

3. The terms of reference for this inquiry are broad; our submission relates mainly to the second point of inquiry: “The committee wishes to address the distribution and quality of GP services and their influence on health inequalities and asks how the Quality and Outcomes Framework (QoF) and practice-based commissioning might be used to improve the quality and distribution of GP services to reduce health inequalities”. It draws upon our members’ experience in delivering primary care services and our most recent research.

4. The inquiry comes at a time of wider reform of the NHS as envisaged by the interim report of Lord Darzi in November and the prime minister’s announcement of a new preventative health focus for the NHS and the wider acceptance of the principle of personal budgets for those with chronic conditions. Increasingly, these reform ideas recognise that the NHS must be more innovative and agile if it is to respond effectively to the new health challenges identified by government.

5. The following submission makes the case that the best primary care system should offer both equality of access to all patients and equality in terms of the quality of service each patient receives. Competition is the most efficient and effective mechanism for achieving those two goals because it is more likely than a one-size fits all system to create more responsive and personalised services. Competition should work in the patient’s interests by challenging providers to respond more effectively to the health needs of all groups, and rewarding those which do so most effectively.

6. The QOF and practice-based commissioning are important elements in creating more targeted attention to existing health inequalities, but both must be part of a wider policy of NHS reform that ensures an optimum environment in which competition can be harnessed to help commissioners effectively.

7. Our submission suggests:

- Competition can help the NHS achieve both greater equality of access and quality of service in primary care for all patient groups
- The policy framework must create a primary care market which delivers effective commissioning that addresses health inequalities and promotes real patient choice

Competition can help the NHS achieve both greater equality of access and quality of service in primary care for all patient groups

8. Health inequalities are the result of a complex and wide-ranging network of factors. People who experience material disadvantage, poor housing, lower educational attainment, insecure employment or homelessness are among those more likely to suffer poorer health outcomes and an earlier death compared with the rest of the population.

9. This is recognised in the new health inequalities public service agreement, whereby the Department of Health (DH) has a target to reduce inequalities in health outcomes by 10 percent by 2010, as measured by infant mortality and life expectancy at birth. The new operating frameworks by which PCT performance will be measured introduce a welcome benchmark which should stimulate them to look holistically at how they approach different health inequalities.

10. Lack of accessibility of primary and GP services is a particular contributory factor to many individuals from hard to reach groups or living in deprived areas feeling unable to access the NHS. The issue of lack of access is two-fold: capacity and location. As the gateway to other NHS services, registering more people with a GP is a pre-requisite for addressing issues around access. But that is problematic. According to *Which?* one in four surgeries has turned away a new patient; there are also major problems with under-doctoring in many inner city areas, precisely the areas where health inequalities needs effective GP and other primary care services to hand.

11. The most basic step in addressing health inequalities is to ensure access to the NHS through its primary care provision. The current system for delivering primary and GP care services—the main point of access to healthcare—has historically not been able to address multiple health inequalities or reflect the fact that different patient and social groups often have differing needs which are not served by a “one size fits all” system. As a result, the lack of flexibility in existing NHS provision can exacerbate, or at least not help address, health inequalities.

12. The move to practice-based commissioning (PbC) does give GPs the potential to reshape services more around patient needs—and specific health inequalities, such as for example the health needs of isolated minority ethnic groups in inner cities. But PbC has not taken off universally across the country. The primary care trusts have an important role in ensuring GPs deliver more comprehensive, joined-up packages of care by partnering with secondary, community and social care provider. But there needs to be an overall improvement in commissioning at the GP and PCT level to ensure this happens across the board.

13. The best primary care system will offer both equality of access to all patients and equality in terms of the quality of service each patient receives. Accessing a competitive market of providers is the most efficient and effective mechanism for PCTs and GPs to deliver these goals because it works to create more responsive and personalised services, and challenges providers to respond more effectively to the health needs of all groups, as identified by commissioning decisions in the market.

14. If patients are able to choose from a range of providers who can offer alternative solutions which best meet their needs (in terms of access, type of treatment, etc) then people are more likely to engage with the NHS earlier and benefit from a preventative focus in healthcare. Informed patients, faced with a choice of providers (and with support from the PCT commissioners) will act as a challenge to providers of primary care to think differently about the services they offer to patients, or to provide new services where there is a clear need.

15. The CBI showed in our report *Just what the patient ordered* in November 2007 that for PCTs which have identified specific health inequalities providers outside the NHS—from all sectors—are offering alternative options that help them respond to patient needs. So where existing GP provision is not able or willing to address such gaps in access, a competitive primary care market would encourage consideration of other solutions. Barking and Dagenham PCT in East London, for example, in response to major problems with access for a population with significant socio-economic disadvantages, worked with a private provider to run a 7,000 patient GP practice and a 100 patient-a-day walk-in centre, both targeted to meet the identified needs of that population. The market worked here in response to a failure of the existing provision to address an issue of equality of access.

The policy framework must create a primary care market which delivers effective commissioning that addresses health inequalities and promotes real patient choice

16. If the principles of competition, as outlined above, are to be harnessed in the interests of reducing inequalities, the policy framework needs to be effectively designed to ensure a competitive market works in the interests of all the patients. To do that, health policy must:

- Promote effective market management by primary care trusts and GPs
- Develop a commissioning strategy that delivers outcomes which address identified inequalities and promote patient choice

Promote effective market management by primary care trusts and GPs

17. The Department of Health's *Fairness in primary care* initiative to improve access and build capacity in under-doctored areas has encouraged new providers from the social enterprise, voluntary and private sectors to offer services alongside existing GP services in nine PCTs. It should also encourage PCTs to make more use of the alternative provider of medical services (or APMS) contracts, which were designed to deal specifically with some of the root causes of lack of access. These changes, and the current NHS review undertaken by Lord Darzi, can make a significant change to the capacity of local NHS services to recognise and respond to identified inequalities.

18. But PCTs and GPs must manage primary care markets to stimulate innovative approaches that specifically address identified inequalities. No market should be designed to offer the same type of service in the same way to the same types of people in every area. This is not to argue for postcode lotteries, but to accept that the inequalities too are not uniform and so require non-uniform solutions. The commissioning power now available to commissioners creates an opportunity to rethink how different services are designed so they can specifically take account of the health inequalities identified in a particular region.

19. PCT commissioners should be accountable to ensuring the supply side of the primary healthcare market matches patient needs, particularly of hard-to-reach groups and those lacking access. That will require commissioners to act as effective market makers through an on-going dialogue with all providers—public, private and third sector—and ensure information is made available early enough to providers about the health needs profile within a PCT and the desired outcomes from commissioning. It is through this active engagement with the market that new packages of care can arise which are better suited to addressing persistent inequalities.

20. But to ensure the market works in the interests of addressing inequalities, commissioners must also:

- *Remove barriers to entry into the market*
As PCTs shift their role from providers to commissioners, it becomes imperative that they have the appropriate commissioning skills if they are to understand local population needs, secure an appropriate supply base to match those needs, and oversee service re-design so there is a more direct link between provision and identified health inequalities. PCTs become the stewards and designers of the market, so they are required to reduce the barriers to entry to new providers who may offer new solutions to existing health inequalities.

Providers need to be reassured that market entry is relatively easy. Contract costs, for example, need to be minimised. But there are also cultural barriers to the primary care market—including ideological concerns about the use of private providers—which must be addressed so that new ideas, along with new providers, can respond to the signals provided by commissioners about the healthcare challenges that exist.

- *Create capacity within the system*
The example of the introduction of independent sector treatment centres within the NHS has shown the value of introducing additional capacity into the system. They have been vital in helping

meet the government's 18-week waiting time target. Perhaps more significantly, the introduction of new providers into the NHS family has brought new ideas and approaches which the NHS does not always find easy to generate from within.

Fundamental changes to clinical pathways have transformed the fight against infection; the use of mobile units has improved access for patients in remote areas; and new pain management techniques have allowed hip-replacement patients to start physiotherapy earlier, boosting recovery. It is clear from the patient satisfaction levels report in ISTCs that such innovations have made a real positive difference to patients' experience of the NHS. Creating similar new capacity within the primary care market also requires a specific strategy for sustainable market creation.

— *Create a clear mechanism for responding to failure of provision*

New providers—and new ideas—will only be encouraged into the primary care market if there is fluidity in that market and evidence that competition has an effect on poor provision. Competition should reward the providers who are evidently better at addressing health inequalities identified by commissioners; this also means a commitment by commissioners to require poor providers which fail to respond to identified inequalities to exit the system. This will require PCTs to improve commissioning skills so that poor provision can be replaced quickly and commissioners have access to the right information to ensure ineffective services are not retained.

— *Promote a level playing field between all providers, regardless of the sector in which they operate*

The lack of similar treatment between NHS and non-NHS providers is a brake on the functioning of an effective market. Any provider with an unfair advantage in the market means that public spending will be directed away from the most efficient providers, and those providing ineffective services are more likely to remain in place. In particular these include the transfer of NHS pension liabilities; the costs associated with market entry; and the economies of scale affecting the abilities of smaller providers to compete. Similarly, the labour supply needs to be structured to ensure that there is free movement of staff between NHS and non-NHS organisations.

Develop a commissioning strategy that delivers outcomes which address identified inequalities and promote patient choice

21. Effective commissioning, as the inquiry terms recognise, is crucial to addressing health inequalities in a more sustained way, ensuring the NHS becomes much more responsive to patients affected by them. The focus for PCTs on needs analysis, procurement and contract management should help create a more direct link between local needs and measured outcomes. The creation of specific “levers” in this system, including the implementation of “competition principles” is a welcome measure, as it recognises that the most effective commissioning solutions cannot be delivered by the existing NHS structure alone.

22. The changes introduced by the government are the right way forward towards creating a responsive system and are welcomed by the CBI and its members. However, if inequalities are to be addressed effectively, the government must ensure that the reforms it has put in place are implemented fully so that the expertise of all providers is brought to bear to assist PCTs in addressing health inequalities.

23. The inquiry terms ask how best the Quality Outcomes Framework (QOF) and practice-based commissioning can be made to ensure GPs address health inequalities. We would argue that to for these change to be most effective, the following emphases must be considered:

- The QOF could be tailored around addressing health inequalities rather than just outputs
- Practice-based commissioning should improve data capture and dissemination
- The money should increasingly follow the patient.

24. The Quality Outcomes Framework (QOF) could be tailored around addressing health inequalities rather than just outputs. The introduction of the QOF into the new GP contracts aims to reward practices which deliver high-quality services to all their patients. It is evident that since its introduction that GPs are doing more to address long-term conditions like coronary heart disease. But we think the QOF mechanism as currently structured is still too focused on outputs from primary care delivery, and is insufficiently focused on outcomes relating to health inequalities. An overly prescriptive QOF will do little to encourage innovative approaches to tackling pre-existing inequality issues.

25. Practice-based commissioning (PbC) should improve data capture and dissemination. PbC has the potential to encourage GPs to offer more specialist surgeries in their practice, such as diabetes care or dermatology, or focus on tailored education and prevention programmes with key groups around alcohol dependency or obesity. It should be used to encourage GPs to link up with secondary, community and social care providers to offer more concerted programmes that address existing health inequalities. But at the moment, PbC is not working effectively enough to address health inequalities because too many GPs are failing to share the data they have early enough with all providers, which is a necessary precondition for those providers to work with GPs to develop solutions to address inequalities.

26. Empowered patients with real choice are more likely to seek to engage with the NHS if they can see that the service on offer is right for their needs. Patients should be allowed to choose from any willing provider that meets NHS tariff costs and quality standards.

27. Good data must be at the heart of making choice within this market work in the interests of patients. Informed patients drive change. It is only when PCTs have good broad data about health needs that an appropriate strategy can be designed in response.

28. The partnership between Birmingham North East primary care trust and its *OwnHealth* scheme is a good example of how effective data gathering helped shape a redesign of the system to address the particular needs of a hard-to-reach group. *OwnHealth* is a personalised programme of personalised healthcare support to help people manage long-term condition such as cardio-vascular disease and diabetes. In Birmingham, 27% of people have a long-standing limiting illness which contributes to an evident gap in outcomes; *OwnHealth* is also designed to respond to the fact that delivery to ethnic minority groups is itself another recognised inequality that was not addressed effectively by existing provision.

29. Working with Pfizer Health Solutions, the system creates personalised health plans in line with national guidelines, and new software is used to provide decision support and capture data on progress. The PCT provides clinical support, patient identification and stratification, and it is a crucial part of the programme that patients facing health inequalities are part of the solution and encouraged to have control over their own health goals. So far, over 700 patients have managed to reduce their blood pressure using this system, reducing numbers of GP admissions and referrals. The cost per patient is £500, but with the cost of going into hospital being £2,500, the cost benefits of this approach are evident.

30. This is a positive example of how intelligent commissioning can create a solution tailored to address specific health inequalities identified by the data measured by a PCT. It also demonstrates the importance in any approach to addressing inequality of access of ensuring that the solution is accessible.

31. But too many PCTs are demonstrably not collating sufficient data about their local health needs sufficient to develop an effective response; it is also the case that too often, data which would help providers to develop effective solutions is not shared effectively with them by PCTs. It is also clear from our members' experience that far too many GPs do not know how to effectively use the data available to them.

32. As well as basing commissioning decisions on transparent and wide-ranging data, it is also crucial that primary care trusts can ensure all patient groups can easily access information not only about NHS services and their rights within them, but also about specific personal and public health issues. PCTs should be looking at a more creative use of technology to ensure hard-to-reach groups can access information they need; this could be through touch screens (like in job centres) placed in surgeries, pharmacies, libraries, supermarkets and benefits offices.

33. The money should increasingly follow the patient. The success of individual care budgets in social care indicates that people benefit from having the choice of a range of different providers offering alternative packages of care, allowing them to opt in to the package best suited to their needs. Those GPs or primary care providers who are the most successful at addressing identified health inequalities—demonstrated by increases in patient numbers or increased access by target patient groups—should be funded to reward successful service innovation that addresses issues of access.

Public Services Directorate

January 2008

Memorandum by the NHS Confederation (HI 90)

THE CONTRIBUTION OF THE NHS TO REDUCING HEALTH INEQUALITIES

The NHS Confederation is the independent membership body for the full range of organisations that make up today's NHS. Our membership includes over 95% of NHS organisations—acute trusts, ambulance trusts, mental health trusts, primary care trusts, foundation trusts and special and strategic health authorities. Independent sector members who provide NHS services are also part of the NHS Confederation. We also represent NHS organisations on workforce issues through NHS Employers.

The NHS Confederation welcomes the opportunity to give evidence to the Health Select Committee on health inequalities. Health inequalities is one of the starkest health challenges facing Britain today and, working with other departments, must be the Department of Health's top priority. This evidence sets out our views, based on feedback from a cross section of our member forums and networks.

The NHS Confederation is currently undertaking a major programme of work on health inequalities, which starts from the premise that, while reducing the gap in health inequalities is a huge multi-agency issue, health has a lot it can do to improve the current situation.

EXECUTIVE SUMMARY AND RECOMMENDATIONS

- All parts of the health and social care system have a specific role to play in assessing and delivering services designed to reduce health inequalities in access, outcomes and life expectancy.
- Recruiting the best clinicians to work in highly deprived areas is often a problem for NHS organisations. PCTs in these areas need to find ways to incentivise and support clinicians to choose to practise in areas of high deprivation. By understanding clinicians' financial and professional motivations, PCTs need to design schemes which will improve recruitment and retention in these areas.
- Addressing health inequalities requires a partnership approach between the NHS and other organisations such as local authorities. To achieve effective partnership working, the new Local Area Agreement system should be allowed time to develop and embed. Also, the Joint Strategic Needs Assessment has a central part to play and must be a robust and inclusive process to ensure that the needs of all communities are addressed in service plans.
- Consideration should be given to whether there would be advantages to making some of the resources for tackling health inequalities directly available through the Local Strategic Partnership (LSP).
- The funding of primary care needs to be reviewed to incentivise action to address unmet need and health inequalities, for example by incentivising practices to actively seek out new patients from deprived communities. As part of this, the Minimum Practice Income Guarantee (MPIG) should be replaced in its current form or phased out relatively rapidly in conjunction with the establishment of a target capitation figure for practices.
- Under the Local Government and Public Involvement in Health Act 2007, certain NHS organisations have a statutory duty to partnership through the LSP. This affects NHS trusts, primary care trusts and foundation trusts but not other providers such as GPs or independent providers. However, it is important that all organisations involved in NHS services play their part in the commissioning and delivery of local services designed to reduce inequalities relating to access.
- The wider implications of geographical differences, for example rurality and its impact on equitable access to services, as well as challenges in urban areas, need to be recognised in funding allocations.
- There are great benefits to be had from joint appointment of public health specialists at both local and regional level.
- The strengthening of local partnerships should be mirrored across Government to ensure coherence of policies which impact on health inequalities.
- The PSA targets for health inequalities should be revised to reflect health inequalities evident between the key diversity strands.
- The Single Equality Bill should include a legal definition of "positive action".

THE NHS CONTRIBUTION TO REDUCING HEALTH INEQUALITIES

Health inequalities is a term with many different definitions. For the purposes of this inquiry, we suggest that it covers:

- Inequalities in access and the opportunity to use healthcare
- Inequalities in the outcomes from healthcare
- Inequalities in life expectancy and quality of life.

While the NHS Confederation would argue that the health service can do more about inequalities in access, less can be done by the NHS alone to improve inequalities in outcomes from healthcare. Inequalities in life expectancy and quality require a broader range of partners to be actively involved and will be the most intractable of the three areas in which to measure positive change in the short to medium term.

The NHS Confederation believes that all parts of the health and social care system have a role to play in assessing and delivering services designed to reduce health inequalities. This includes primary care and general practice, NHS commissioners and the providers of NHS services and specialist public health practitioners at PCT and regional level. Without strong local, regional and national partnerships, change cannot be brought about.

For the NHS to reduce health inequalities significantly the development of high quality commissioning will be vital. PCTs, working with the Department of Health (DH), have developed a programme to deliver the commissioning skills required. The programme aims to obtain the best value and health outcomes for local citizens by understanding their needs and then specifying and procuring services that deliver the best possible health and social care outcomes within available resources.

In addition to strengthening commissioning through the World Class Commissioning programme, to tackle inequality in access the NHS must prioritise finding the people who are not accessing the services they need. This requires significant investment nationally and locally in sophisticated data and disease mapping to enable a better understanding of who and where the missing people are. This investment should include incentives for primary care to “case-find”—identifying those at greater risk of certain conditions.

Improving access is also a crucial part of tackling health inequalities. We must change the incentives in the NHS to better serve those patients from poorer backgrounds at the early stages of disease. In these early stages, it may be possible to improve outcomes; however those from poorer economic backgrounds are failing to access preventative and proactive services. Three first steps to improve access to services would be to:

- Remove the minimum practice income guarantee which prevents equitable distribution of resources.
- GP practices are given around £600 million a year according to their historic levels of funding rather than the real needs of patients. Known as the minimum practice income guarantee (MPIG), this payment may disincentivise practices from case-finding and should be abolished.
- Change the formula for paying GPs to ensure practices in deprived areas don’t lose out.
- The Quality and Outcomes Framework (QOF), a new method of rewarding performance, pays practices with high disease levels at a lower rate per patient than practices with low disease prevalence. This means that the existing payment system has disadvantaged certain practices, which may be those in deprived areas.
- Design local services that reach out to the community and don’t expect the community to come to the service.
- Extending opening hours in the evenings and at weekends is of course important. But improving access to traditional services may not be the most effective way to tackle health inequalities in some excluded groups. Getting behind the reasons for inequality requires a much more sophisticated approach.
- Many PCTs are using new ways of reaching out to local communities. For example, in Tower Hamlets there were plenty of dentists, but people weren’t using them. The introduction of a mobile screening service to travel round the local community, proved to be the solution—30 per cent of those attending had never been to a dentist before. And more than half went to a high street dentist within a month of visiting the mobile service.

DISTRIBUTION AND QUALITY OF GP SERVICES

Concerns have been expressed about the relative distribution of GPs since the creation of the NHS in terms of both numbers and quality. In general, the distribution and quality of GPs has reflected the inverse care law, which means that fewer GPs are available in deprived areas. Whilst there is very good primary care in deprived areas there appears to be a wider range in terms of quality. This has continued despite an overall increase in the total number of GPs and the availability of financial incentives to those willing to commit to working in deprived areas. When investigating the issues which were most important to those London GPs considering a practice move, a survey in the late 1990s demonstrated they were most disinclined to work in practices with high deprivation among the patient population.

In the future, improving access to primary care services needs to be locally responsive, grounded in both clear needs assessment and through high quality public and patient involvement in the design of services. In parallel with this, it is important for PCTs to understand both the financial and professional motivations of clinicians choosing to practice in areas of high deprivation and create schemes which enable these clinicians to flourish and attract others with similar values.

There would be an advantage to reviewing the funding formula to ensure that there are effective incentives for practices to identify those at greater risk of certain conditions, especially within deprived communities. In addition to this is the future of the MPIG. Competition between practices to provide high quality and accessible services can be used as a method of improving quality and access. This can be achieved by encouraging new entrants and, where lists are not full, selectively contracting existing practices. This is not only another reason to replace MPIG or phase it out relatively rapidly, but also implies that practices should be rewarded for the number of patients they have registered. In addition, walk-in centres and out-of-hours providers should be encouraged to register patients and therefore also become eligible for these rewards.

THE ROLE OF THE QUALITY AND OUTCOMES FRAMEWORK

The relationship between the Quality and Outcomes Framework (QOF) and health inequalities is complex. Current results are conflicting with some studies showing an association between poorer QOF performance and higher levels of deprivation. Others do not show this link. QOF achievement can also be adversely affected by other characteristics of the practice, patients, practitioner and local area, for example practice size; the proportion of practitioners aged over 50 years; the proportion of practitioners who trained

outside of the UK; and the proportion of patients over the age of 65.⁶⁹⁹ Conversely higher QOF achievement has been found to be associated with other characteristics including training practices, group practices and a higher ratio of practitioners to patients⁷⁰⁰. Practices with these characteristics may be less likely to exist in socially deprived areas.

DIFFERENT TYPES OF QOF INDICATORS

QOF indicators themselves can generally be characterised as either process or outcome measures. Process measures are those which relate to activities performed by the clinician such as recording of a blood pressure measurement within a specified time period. Outcome measures are those which measure whether the patient achieves the desired result, for example the optimal control of blood pressure, and are not usually within the control of the clinician to the same extent as process measures.

BASING INCENTIVES ON THE RIGHT INDICATORS

While providing a financial incentive for the achievement of health outcomes seems sensible, there is limited evidence that this has the desired effects. This is due primarily to the fact that the relationship between healthcare and health outcomes is not direct and is dependent on some factors out of the control of healthcare providers. This may be why most incentive schemes focus on technical care measures.

That said, there is an emerging evidence base for “tightly linked” process measures⁷⁰¹, which have a stronger relationship with the desired health outcome and allow for the targeting of those at highest risk. While these have a more complex indicator construction, it is argued that they are superior to simple process measures and outcome measures for the following reasons:

- They recognise and encourage organisations to do the right thing especially in regard to those patients who may never achieve the ideal target
- They identify those patients at highest risk of poorer outcomes and therefore most likely to benefit from the intervention
- And because of the strong link between the process and the outcomes the intervention most likely to improve the outcome is explicitly incorporated into the measure.

The potential for QOF to be a comprehensive indicator of health outcomes is limited for the reasons outlined above. This means that there are likely to be greater health gains across the wider population by focusing QOF on appropriate measures rather than those based solely on outcomes. The main risk to the delivery of these gains relates to the concept of exception reporting. To date, evidence⁷⁰² of gaming in the implementation of exception reporting is limited but the management of exception reporting forms a key element of the PCT role in the monitoring of the QOF.

FOCUSING RESOURCES TO AREAS OF HIGH MORBIDITY

The value of a QOF point at a practice level is adjusted both for the number of registered patients and for the number of patients on the individual disease register (prevalence). This reduces variation in payment between practices and targets resources at areas of high morbidity, and therefore indirectly addresses some aspects of health inequalities. Using Scottish data, researchers have examined the effect of using this method to calculate payment.⁷⁰³ They have found that, while its use is successful in reducing variations in practice income, it did not achieve its secondary objective of focusing resources to areas of high morbidity. Therefore, the QOF prevalence adjustment should be reviewed to incentivise action to address unmet need and health inequalities.

THE SUCCESS OF NHS ORGANISATIONS AT CO-ORDINATING ACTIVITIES WITH PARTNERS

Solutions to address the causes of inequality require a broad coalition of action that goes well beyond the NHS to address poverty, employment and housing (please see appendix one for an example). A concerted effort from both health and local government will be especially important and they will need to use their newly strengthened statutory duty of partnership to improve local services by working closely together.

⁶⁹⁹ Doran T, Fullwood C, Gravelle H, Reeves D, Kontopantelis E, Hiroeh U, Roland M. Pay for performance in family practices in the United Kingdom. *New Engl J Med* 2006; 355: 375–384.

⁷⁰⁰ Ashworth M and Armstrong D. The relationship between general practice characteristics and quality of care: a national survey of quality indicators used in the UK Quality and Outcomes Framework, 2004–05. *BMC Family Practice* 2006; 7:68 doi:10.1186/1471-2296-7-68 (<http://www.biomedcentral.com/1471-2296/7/68> accessed 27 July 2007).

⁷⁰¹ Kerr E, Krein S, Vijan S, Hofer T, Haywood R. Avoiding pitfalls in chronic disease quality measurement: a case for the next generation of technical quality measures. *Am J Manag Care* 2001; 7: 1033–1043.

⁷⁰² Doran T, Fullwood C, Gravelle H, Reeves D, Kontopantelis E, Hiroeh U, Roland M. Pay for performance in family practices in the United Kingdom. *New Engl J Med* 2006; 355: 375–384.

⁷⁰³ Guthrie B, McLean G and Sutton M. Workload and reward in the Quality and Outcomes Framework of the 2004 general practice contract. *Br J Gen Pract* 2006; 56: 836–841.

The multifaceted nature of health inequalities requires a partnership approach including joint needs assessment, planning and service delivery. This would be best achieved through utilising the LSP as the co-ordinating body at local level. In addition, active NHS participation will be necessary in the development of local outcome measures and the delivery of Local Area Agreement improvement targets. In this, we would stress that a robust process for Joint Strategic Needs Assessment is a vital part and we welcome the recent guidance supporting this new development. We hope that the new system will be given time to embed into local processes and that good practice will be shared through bodies such as the Care Services Improvement Partnership and other regional presences.

However, the system needs to ensure that this collaboration is not undermined by excessive bureaucracy. Planning and reporting processes must be streamlined to ensure that partnership is encouraged rather than seen as an additional and onerous task. A duty of partnership in the Local Government and Public Involvement in Health Act (2007) does not recognise the importance of all providers of NHS services, including independent sector, general practices or third sector providers, having the same duty of partnership. We believe it is important that all providers of NHS services play their part in the commissioning and delivery of local services designed to reduce inequalities, whether covered by the duty or not.

Funding should not be ring-fenced to specific issues where inequalities exist, such as stroke or obesity, as the underlying causes of inequality will vary from PCT to PCT area and ring-fencing can lead to investment in areas of less priority to the detriment of more pressing local issues. However, consideration should be given to whether there would be any advantage to making some of the global resources for tackling health inequalities directly available through the LSP. Doing so would mean funding decisions can be made that are locally sensitive and agreed by all partners. The development of the Comprehensive Area Assessment supports this by enabling accountability and transparency to be assessed at partnership rather than individual organisational level.

However, the Confederation is concerned that the wider implications of geographical differences are sometimes not recognised in funding allocations. For instance, in rural areas deprivation can be related to “churn” for example of migrant workers, whose needs may not be picked up in needs assessments and for whom case-finding can be difficult. Similarly the ability to address these inequalities may be compromised by the increased costs of travel and, hence, of service delivery particularly for long term, low level interventions in sparse populations. These local differences between LSPs should be taken into account in framing any new incentives within the existing system.

THE ROLE OF PUBLIC HEALTH SPECIALISTS

The NHS Confederation considers that joint appointment of public health specialists at both local and regional level should reap great benefits (please see appendix two for an example). In particular, their expertise and input to joint needs assessment and service planning is crucial when designing effective services aimed at addressing health inequalities. They can also serve as a bridge between local government and the NHS and enable the wider implications of health inequalities to be taken into account in planning other local services. However, whilst the case for these joint appointments is intuitively strong we would like to see formal academic evaluation of these initiatives and their impact on key decisions.

CO-ORDINATING POLICY BETWEEN GOVERNMENT DEPARTMENTS TO COMPLEMENT LOCAL PARTNERSHIP WORKING

The NHS Confederation believes, there should be a strengthening of cross-governmental arrangements to mirror local partnership working, such as the dual key system for children’s services. This would ensure that departmental policies support and enhance local partnerships rather than produce guidance in isolation. We welcomed the cross-cutting Public Service Agreement (PSA) targets recently announced as part of the Comprehensive Spending Review and hope that these will encourage further an inter-departmental approach to policy-making. These are challenging targets. Sustainable reductions in inequalities require a long-term approach that enables cultural and economic aspects to be addressed alongside those over which the NHS has more direct impact.

The NHS Confederation believes that national target setting on a few key areas must not be considered in isolation. While continued improvements are obviously to be welcomed, in the most deprived areas, dramatic improvements may still leave a PCT area as an outlier nationally. This can have an impact on morale and on overall performance ratings which cancel out some very innovative approaches and prevent learning from examples of good practice in some cases.

The Confederation believes that targets should be formulated which reflect the inequalities in access to healthcare, quality of delivery, and appropriateness of provision which exist for all of the diversity strands—particularly, disability, age, gender, race, religion or belief.

At a practical level, the specific legal obligation to develop equality schemes and to carry out equality impact assessments has the potential to help shape local priorities. Conducting and using the evidence to create meaningful dialogue with communities is central to effective commissioning and service provision.

However, we believe that the processes, as currently defined, can prove overly bureaucratic and time-consuming for NHS organisations to support. We would therefore welcome a re-evaluation of the approach, with a view to simplifying the requirement.

The harmonisation of the current equality legislation proposed in the Single Equality Bill and the creation of the new single regulatory body (Equality and Human Rights Commission) should help to clarify the actions needed to be taken by NHS organisations. This in turn should result in a more consistent approach to tackling health inequalities locally and nationally, which is to be welcomed.

Current legislation permits the use of “positive action” (or balancing measures) to address an imbalance in employment opportunities among targeted groups. While this is undoubtedly a potentially powerful lever in addressing aspects of inequality there is some confusion across the NHS about its legitimate use. Our own research suggests that employers would welcome the clarity and reassurance that a widely accepted—or even legal—definition of “positive action” would bring. In our formal response to the recent Discrimination Law Review consultation, NHS Employers set out our working definition of “positive action” as a contribution to the debate.

USING THE POWER OF THE NHS AS A CORPORATE CITIZEN

The NHS employs 1.3 million people, more than any other organisation in the UK. The power this gives the NHS as a local employer could be used much more effectively to tackle inequalities.

As part of the local community, the NHS has a considerable role to play working with other agencies to find broader solutions to health inequalities. Harnessing collective power, services must work together locally to put health inequalities at the heart of local priorities. Tackling the root causes of health inequality such as, employment, poverty and housing is only possible when the relevant organisations work together.

And the NHS must ensure it offers equal opportunities in employment. Through flexible employment, the procurement and local sourcing of goods and services, and in supporting its employees to put back into the community through volunteering, the NHS can enable local communities to reduce health inequalities for themselves.

NHS Confederation

January 2008

Appendix One

Case study: partnership working in child and adolescent mental health

The review of mental health services for children and adolescent, recently announced as part of the Children’s Plan, will allow for a greater focus on preventative measures in child and adult mental health services (CAMHS) and there is certainly more to be done in this area.

In our *Maintaining the momentum report*, we highlighted how investing in these services can prevent problems persisting into adulthood, with the accompanying vicious circles of social exclusion, lost productivity and heavy service use. Studies have shown that public service costs incurred in adulthood, by individuals diagnosed with mental health problems in childhood, can be up to ten times more than the cost of people with no such history—these include costs related to health services, social care and the criminal justice system. These findings highlight the long-term benefits of investing in prevention and education initiatives, as well as early intervention.

The National Institute for Health and Clinical Excellence (NICE) is producing guidelines about primary school interventions by teachers and other school professionals both at whole-school level (for example, mental well-being classes) and at targeted level (for vulnerable children and those with emerging problems). If such initiatives are correctly resourced, there is potential for improved recognition and early intervention when problems first surface, ensuring fewer children are referred with mild problems and children who really need help are referred in a timely manner.

Appendix Two

Case study: joint appointments leading to better preventative work

Increasing numbers of PCTs and councils are jointly appointing directors of public health. When Blackpool PCT and the council appointed their joint director of public health, they analysed the area’s position as having the second-worst life expectancy for men in England and Wales. They found several reasons for this, including injuries and a range of falls prevention and road safety activities for older people reduced the number of people admitted to hospital.

Memorandum by Pfizer Limited (HI 92)

THE CONTRIBUTION OF THE NHS TO REDUCING HEALTH INEQUALITIES

EXECUTIVE SUMMARY

Pfizer welcomes this opportunity to submit evidence to the Health Select Committee's inquiry into the contribution of the NHS to reducing Health Inequalities.

Pfizer believes that clinicians should have the right to prescribe whichever treatment they feel will be most efficacious and beneficial to each individual patient and that the NHS should provide the support, finance and infrastructure to enable this.

This is in line with National Institute for Health and Clinical Excellence (NICE) and Department of Health (DH) national guidance, but at local level, this guidance is not always followed, for a variety of reasons, leading to health inequalities in the provision of medicines to patients.

As a consequence of our experience in dealing with health inequalities in treatment both in the UK and elsewhere in the world, Pfizer believes that the NHS can achieve a reduction in health inequalities by addressing two key issues:

1. that of differential access to medicines and services across the UK, which can be rectified through reform of the current Health Technology Assessment (HTA) process and local level NHS reform to eliminate inequalities including "postcode prescribing".
2. the issue of unequal access to lifestyle and healthcare information. In addressing this issue, the NHS should take into account the huge and largely untapped potential that closer partnership with the pharmaceutical industry holds for the provision of information to patients.

Pfizer is already working successfully with the NHS to eliminate health inequalities at individual Primary Care Trust (PCT) level and will welcome the opportunity to work much more closely with the NHS to achieve the same results on a UK-wide basis.

1. SITUATION

1.1 Pfizer's core contribution to reducing health inequalities in the UK is through the medicines we produce. Many of these medicines treat diseases that are caused by health inequalities, yet in certain geographies and circumstances, patients are denied access to them, leading to further health inequalities.

1.2 Cancer medicines alone now comprise around 30% of Pfizer's product portfolio, alongside products for use in therapy areas including respiratory and cardiovascular disease.

1.3 However, our engagement alongside healthcare providers in the UK and in healthcare services across the world has given us insight into world-class patient relationships that facilitate treatment in primary and secondary care.

1.4 Likewise, the evolution and diversification of our company and industry into the fields of disease management and the psychological needs of patients, as well as investigation of socio-economic mapping and diagnostic tools, is reflective of the manner in which we believe the NHS should address health inequalities in the future and demonstrates the potential for partnership with pharmaceutical companies.

1.5 In our view, there are two key points around health inequalities that the NHS in the UK should and can address:

- 1.5.1. Health inequalities, as they relate to the NHS, are frequently created and exacerbated by differential access to medicines and services.
- 1.5.2. Asymmetrical access to healthcare information has the same negative impact, often due to differing demands on NHS resources at local level. Addressing this issue through a partnership approach with industry has enormous potential and the NHS needs to consider how this can be achieved without diminishing its independence and public service ethos.

2. ACCESS TO MEDICINES AND SERVICES

2.1. Despite government efforts to eliminate "postcode prescribing", it still exists for a number of different reasons, denying patients in specific geographical locations access to medicines.

2.2 One example of this is devolution, which has led to different appraisal bodies deciding which medicines to make available in each country, based on very different HTA criteria. This lack of standardisation across the UK has even led to people moving across borders in order to obtain treatment for conditions that they cannot receive in their home country.

2.3 There is therefore a clear need for reform to address this issue so that the Scottish Medicines Consortium (SMC) and NICE in England, Wales and Northern Ireland standardise guidance and HTA methodologies.

2.4 However, HTAs themselves are at the heart of the postcode prescribing problem, a fact that has been recognised in some of the recommendations of the House of Commons Health Committee (HSC) investigation into NICE, published on 09th January 2008.

2.5 The HSC call for the creation of an independent commission to review thresholds for Quality Adjusted Life Years (QALYs) is a potentially positive step. However, we believe that any reduction in the QALY threshold, whether in the context of a brief initial assessment (as recommended in the HSC report) or a full assessment, can only exacerbate the existing health inequalities situation by denying yet more patients access to the clinically proven medicines that they need.

2.6 Furthermore, we believe that such an independent commission should go beyond the recommended composition of NICE, DH and PCTs to include industry, academia and patients. In addition, this group should have a wider remit, to review and negotiate the joint development of models and approaches. This should include work to:

- 2.6.1. broaden the approach taken to calculating the value of medicines, including the HSCs recommendation to include factors such as the impact on patients and caregivers
- 2.6.2. understand how a flexible approach to, and broader thresholds for, Quality Adjusted Life Years (QALY) might be introduced for certain priority disease areas and accept the limitations of using QALYs to measure the value of medicines
- 2.6.3. ensure that the appeals process is fully transparent and independently overseen
- 2.6.4. ensure that assessment methodologies and assumptions etc. are standardised
- 2.6.5. further research is required to develop more robust, inclusive and transparent methodologies for valuing medicines. These need to acknowledge the variations in patient response to medicines and the limitations of applying population level models to individuals.

2.7 The HSC findings also noted the differences in thresholds and preparedness to use newer technologies between PCTs. This is a familiar picture in England and stems from budgetary issues, with two key areas for concern being readily identifiable:

- 2.7.1. Some PCTs arbitrarily decide to deny patients certain medications because of their own budget priorities, going against NICE and DH guidelines and thus creating geographical inequalities. As a direct example of this, Pfizer has a smoking cessation product that was approved by NICE more than six months ago and which is still being either refused to patients or only made available as a second or third line treatment in some twenty PCTs across the country.
- 2.7.2. Clear health inequality is generated by differential approaches to exceptional case review at PCT level. The most often cited examples concern oncology treatments, when Cancer Networks receive different levels of support and funding from PCTs regarding a particular medicine. As has been recognised by the HSC, this can be dependent on the evaluation criteria and thresholds used by individual PCTs to fit with their own budget availability and which differ from the process and thresholds used by NICE. This leads to situations where some patients can receive one form of treatment as standard when others who live in close proximity will be denied access to clinically effective medicines and have to apply for them on a case-by-case basis, with no guarantee of approval.

2.8 We believe there must therefore be clear and common standards in every PCT for exceptional case review to avoid postcode driven differences and a willingness on the part of the PCT to conduct this conversation in public. There must also be a common standard across PCTs to reach a decision within a maximum of 2 weeks, since many of the patients caught in this "NICE blight" have terminal illness or time sensitive disease (eg Age-related Macular Degeneration).

2.9 As noted above, lack of available budget is the decisive factor at PCT level. This is despite the fact that while QALY thresholds have been static since 1999, in the intervening period, the NHS annual budget has more than doubled, from £40 billion to £90 billion, meaning that funds for medicines ought to be available.

2.10 The issue is therefore one of forward planning, to proactively allocate budgets in readiness for future need, thus eliminating "postcode prescribing" and the resultant health inequalities. We therefore welcome the HSC recommendation that a change of language should take place where NICE HTAs requiring mandatory funding should be renamed "NICE Directives" in order to avoid confusion and ambiguity.

This state of preparedness can be achieved through closer engagement between the NHS and the pharmaceutical industry in "horizon planning" and medium-term resource allocation to allow adequate provision for new licensed medicines awaiting HTA and for those with a positive HTA decision in-year. This could be achieved through introducing a central fund held at Strategic Health Authority (SHA) level, to be allocated specifically for the purpose of providing these new treatments on a planned rollout as new medicines became available.

2.11 The HSC also recommended that there should be better assessment of the level of uptake of NICE HTA recommendations and we believe PCTs could be measured against one another by the Care Quality Commission or Monitor on uptake and diffusion as well as against comparator countries via an "innovation index".

2.12 An additional policy device that we believe should be used to encourage compliance within the NHS and thus eliminate inequalities in access to medicines is the introduction of uptake incentives at a local level for medicines (or other technologies) that have had a positive appraisal. This incentivisation could be achieved through the Quality and Outcomes Framework (QOF) for GPs and through the introduction of a similar system for medicines (such as chemotherapy) that are only prescribed by hospital consultants.

3. ACCESS TO INFORMATION AND WORKING IN PARTNERSHIP WITH THE PHARMACEUTICAL INDUSTRY

3.1 A key to addressing health inequalities must be the education and empowerment of people, combined with the delivery and availability of the necessary resources—both educational and medical—which are the essential prerequisite to receiving appropriate care.

3.2 The NHS has a vital role to play in an upweighted and ongoing education programme aimed at groups that have traditionally been hard-to-reach, often as a result of factors arising from deprivation.

3.3 In conveying accurate information to patients, we feel that there is a valuable, untapped resource readily available within the pharmaceutical industry and Pfizer will welcome greater engagement with the NHS at all levels, from PCTs upwards, in order to help achieve this.

3.4 With both a commercial interest in producing prescription medicines for use by those patients who most need them and a genuine commitment to improving patient health, Pfizer takes the issue of health inequalities very seriously and has a proven pedigree in working in this field.

3.5 The Pfizer UK Foundation was established by Pfizer in 2005 to address health inequalities across the UK arising from social, economic, cultural and demographic factors. It supports community based projects that tackle health inequalities and which fall outside core NHS statutory funding. The aim is to support projects providing tailored, innovative, modest and local solutions to needs defined by local healthcare experts, social care experts, community groups and charities and can also involve working with innovative thinkers in primary and secondary care. To date the Foundation has donated £2,894,079 (£1 million a year) to 121 projects across the UK, with an estimated 259,137 beneficiaries.

3.6 Our experience of direct engagement at PCT level through other areas of our business, as demonstrated by the two examples below, reveals the potential for effective partnership between industry and the NHS in addressing health inequalities across the UK in the future. Ten Pfizer Local Market Managers (LMMs) are based locally around NHS Strategic Health Authorities boundaries with a specific role to identify health inequalities. They carry out regional strategic assessment which include analysis of population demography's and assessment of health needs across this population. Wherever possible, Pfizer LMMs work in collaboration or partnership with PCTs and Health Care Professionals locally to address these inequalities by providing additional expertise and assistance to reach patients. It must be stressed that the Pfizer LMM input does not in any way promote products—instead, the focus is on supporting disease awareness activities and marketing support.

3.7 In April 2006, Birmingham East and North PCT, UK Pfizer Health Solutions and NHS Direct launched a joint partnership initiative, Birmingham OwnHealth[®], an innovative nurse-led care management service delivered over the telephone to support up to 2000 patients with long-term conditions in Birmingham. The focus is on changing patient behaviour in the disease areas of diabetes, coronary heart disease and heart failure, all of which are frequently associated with health inequalities, while encouraging greater self care.

The early indications from the Birmingham OwnHealth[®] service suggest some significant trends concerning community medical resource access by Birmingham OwnHealth[®] project participants over the past year, most notably:

- A 48% reduction in hospital admissions
- A 53% reduction in A&E visits
- A 32% reduction in GP visits⁷⁰⁴

Other initiatives to improve healthcare in the region may have had an influence on these results, so we are already actively undertaking comparative analysis, cost effectiveness and root cause analysis to see whether these improvements can be translated into more effective use of healthcare resources. We hope to be able to publish the results of this analysis in mid 2008.

3.8 Another example of successful collaboration at PCT level is the Town & Bridge Project in Ipswich, where the council and PCT has set up a group called the One Ipswich initiative. The Town and Bridge wards have a higher death rate than the rest of Suffolk (up to 75% higher) and the One Ipswich group was established to reach out to these two wards. A major part of this initiative has been around smoking cessation, where the PCT and local Stop Smoking Service identified the need for additional resource to engage hard-to-reach smokers. Working in partnership with them, Pfizer investigated reasons for lack of uptake of smoking cessation services in these two wards and identified logistical and transport difficulties as obstacles to accessing the stop-smoking-services. As a result, of this partnership, the SSS, PCT and the

⁷⁰⁴ All three statistics from Birmingham OwnHealth[®] report "Successes and learning from the first year" report September 2007, Page 26. Birmingham East and North PCT, NHS Direct and Pfizer Health Solutions.

Town and Bridge project manager established three new clinics in the community in October 2007, using experts such as nutritionalists and exercise specialists to assist patients and create a fully informed and incentivised “willing quitter”. Pfizer added marketing expertise to support this initiative, which included utilising interior and exterior bus advertising on those routes passing through the Town and Bridge Wards that serviced the new clinics and placing posters and materials at Ipswich Town football club matches. Results are currently being evaluated, but the principle of ensuring that patients can access the services they need is one that must be applied across the board to target hard-to-reach population groups.

RECOMMENDATIONS

- Reform and standardisation of Health Technology Assessments by NICE and the SMC, including greater transparency, flexibility and the establishment of an independent commission to review and negotiate the joint development of models and approaches.
- “Horizon planning” in partnership with industry and the establishment of a fund held at SHA level to be used for new licensed medicines awaiting HTA and for those with a positive HTA decision in-year.
- The establishment of clear and common standards in every PCT for exceptional case review and to ensure decisions are made within a two week period.
- The introduction of uptake incentives at a local level for medicines (or other technologies) that have had a positive appraisal, through QOF for GPs and a similar system for other groups such as consultants.
- Partnership between the NHS and the pharmaceutical industry at national rather than local level to achieve the best possible outcomes for patients, combining industry resources and expertise with the experience and professionalism of the NHS at educational and programme implementation levels.

January 2008

Memorandum by ABPI (HI 93)

HEALTH INEQUALITIES

The ABPI welcomes this Inquiry into health inequalities and hopes that this will add to the Committee’s thinking.

1. INEQUALITIES IN PATIENTS’ ACCESS TO MEDICINES

1.1 The Department of Health and ABPI, commissioned by the Ministerial Industry Strategy Group, conducted a joint study as part of the Long Term Leadership Strategy in Medicines (LTLS), which reported in February 2006⁷⁰⁵. This was a statistical analysis of 13 therapeutic areas covering over 50% of medicines expenditure in England to investigate changes in rates of prescribing over time and geographical variation within England. It also identified areas with consistently “high” or “low” prescribing. The MISG regarded this as an extension of the analysis conducted for the report *Variations in usage of cancer drugs approved by NICE—Report of the review undertaken by the National Cancer Director*, which was published on 14th June 2004 and showed major differences in the rate of uptake of cancer medicines approved by NICE across England.

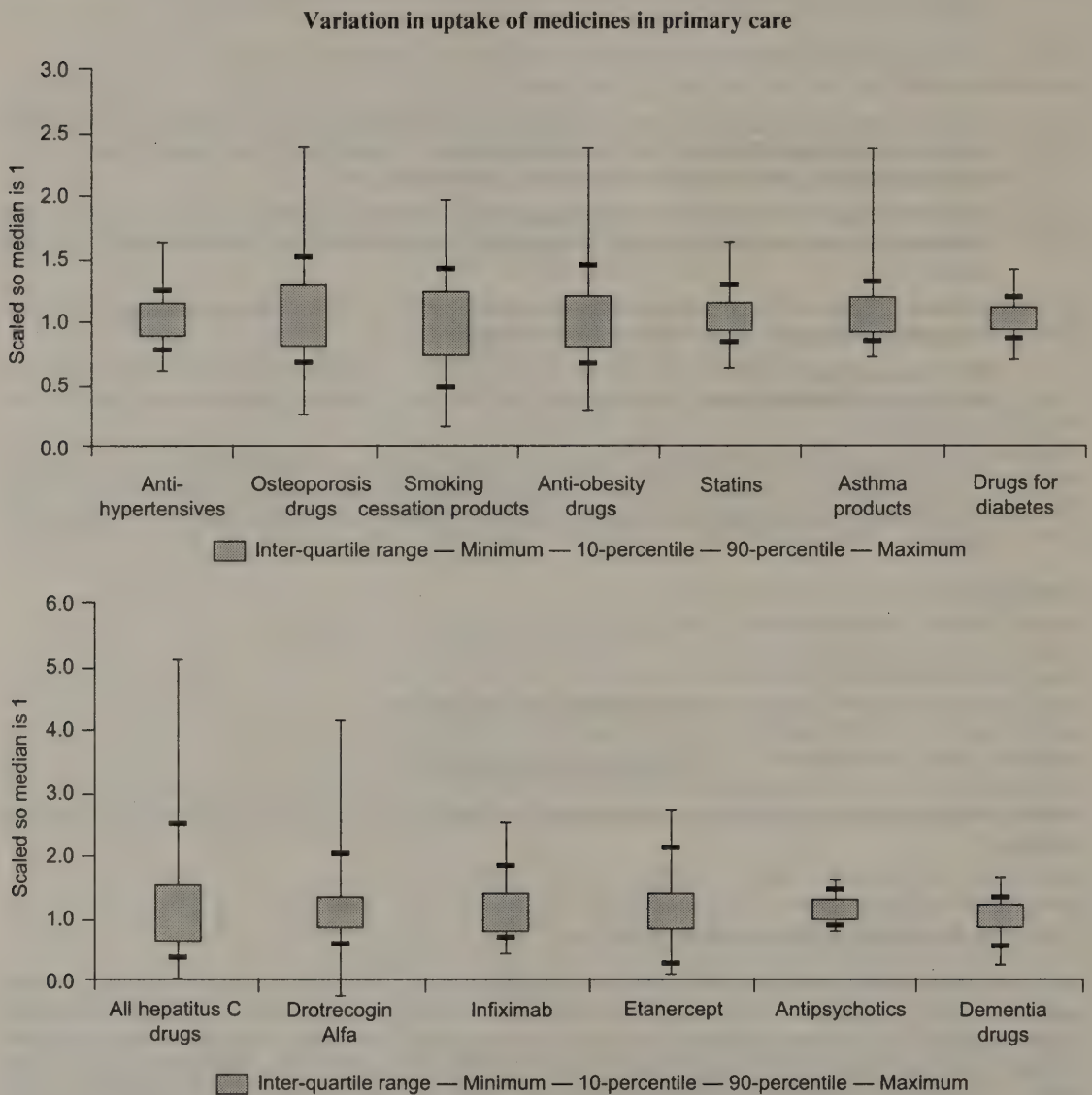
1.2 The LTLS study looked at:

- trends in England over time;
- variation between geographical areas—at lowest possible sub-national level;
- changes in variation over time.

1.3 The medicines examined covered a wide range of therapeutic areas, some including only one or a few chemical entities and others including a substantial number. In each therapeutic area there existed NICE guidance and/or a national service framework, or some other guidance on the use of the relevant medicines. The therapeutic areas included a mixture of those where medicines are used mainly or exclusively in primary care, mainly or exclusively in hospitals, and where therapies are initiated in hospitals or clinics and then continued in primary care. Volume, rather than value, measures were used.

⁷⁰⁵ Medicines uptake in England: a quantitative analysis of variation
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4142751&chk=n5zhYN

1.4 The study found that volume of medicines use has increased but that the rate of increase varied substantially, especially in newer medicines and in those used mainly in secondary care. Further analyses took place to establish factors that could explain the variation in use of medicines between localities. Variation could not be fully explained by disease prevalence, nor was there a significant relationship with relative deprivation in different geographical areas.



1.5 Further, qualitative, research was undertaken to establish reasons for variation⁷⁰⁶. The key drivers of prescribing were reported to be:

- in primary care: the Quality and Outcomes Framework (QOF) of the General Medical Services contract, clinical attitudes and preferences as the main drivers; with funding and financial status and national priorities secondary drivers;
- in secondary care, NICE guidance and clinical attitudes and preferences as the main drivers, with funding and financial status, national priorities and pharmaceutical industry activity secondary.

1.6 The processes used by PCTs to manage the introduction of new medicines had an impact, with processes tending to be more streamlined in PCTs with higher levels of uptake, whereas processes with lower levels were more complex and lengthy. The ABPI's conclusion from this, and the experience of our member companies, is that local management processes have a major part to play in determining the equality of patients' access to medicines. Such processes include the general approach taken by PCT managers to communication and engagement with local prescribers and stakeholders; with those PCTs taking a more proactive, open, consultative approach achieving greater engagement and earlier, more consistent prescribing.

⁷⁰⁶ Qualitative analysis of variations in uptake of medicines.

1.7 This work represents the most comprehensive analysis of variations in uptake of medicines in England to date and indicates that substantial inequalities exist in many important areas of prescribing. Patients' access to medicines still depends on where they live. Local management processes and attitudes, along with clinicians' attitudes, have a substantial part to play in these inequalities.

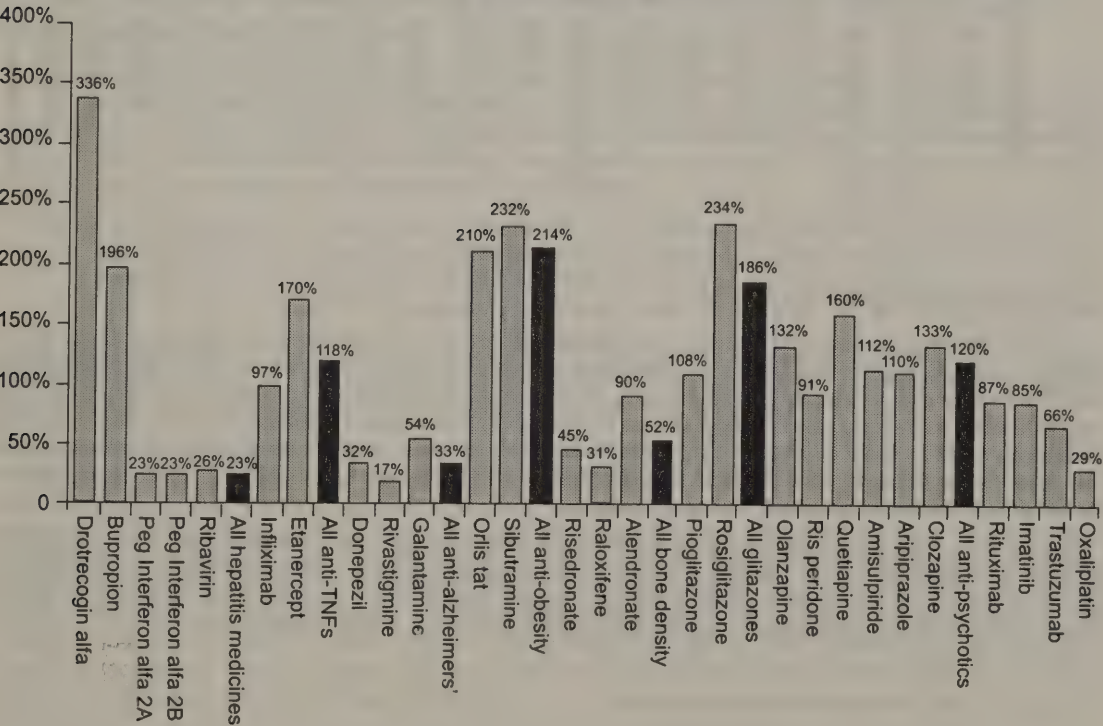
2. INTERNATIONAL INEQUALITIES IN PATIENTS' ACCESS TO MEDICINES

2.1 The Department of Health and ABPI also examined 27 medicines in a sample of 10 therapy areas where new medicines have been launched in the UK in recent years, with treatment areas selected from among those included in the Uptake of Medicines quantitative study above⁷⁰⁷. The analysis used IMS data and compared the rates of medicines use per thousand population in the UK with those in France, Germany, Italy, the Netherlands, Spain and Switzerland.

2.2 There was wide variation between uptake of individual medicines in the UK versus that in the other countries. Two analyses were conducted: comparisons in year 2005 (the latest full year of data available at the time of the study) and comparisons three years from launch in each country.

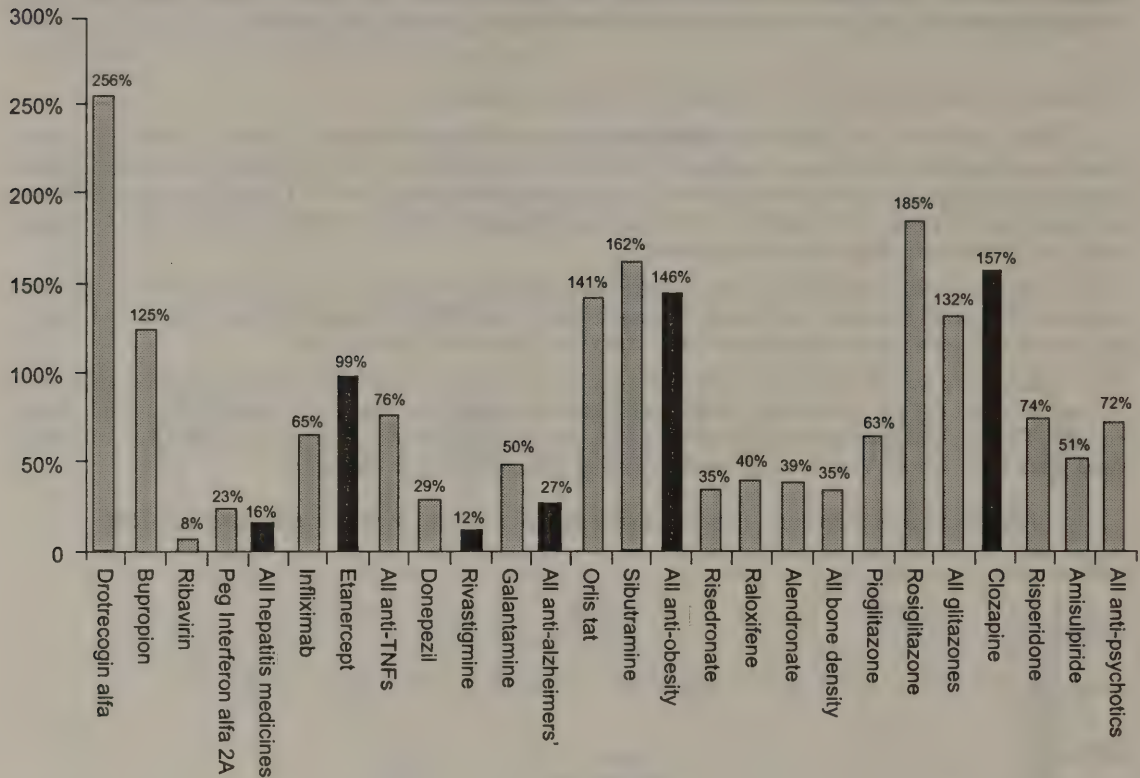
2.3 UK uptake was relatively high for anti-obesity, sepsis and smoking cessation medicines, and low in the case of drugs for the important public health areas of hepatitis C, dementia, osteoporosis and cancer. For anti-TNFs, glitazones and anti-psychotics, UK uptake was high overall in terms of 2005 but not always three years from launch and was not necessarily high for each drug in the group.

UK uptake as a percentage of population-weighted average uptake for comparators—2005



⁷⁰⁷ International comparisons of uptake of medicines.

UK uptake as a percentage of population-weighted average uptake for comparators—three years from launch



3. IMPLEMENTATION OF NICE GUIDANCE

3.1 The Committee has acknowledged in its recent report of its Inquiry into the National Institute for Health and Clinical Excellence that implementation of NICE guidance is variable. One of the objectives of NICE is to improve the quality and consistency of NHS care, and despite many years of concerted effort to support better implementation of its guidance by the NHS, performance remains disappointing. National guidance should be national and the Committee’s report gives some useful recommendations in this regard, not least better focus by the Healthcare Commission on this aspect of NHS core and developmental standards and better measurement of performance.

3.2 What is disappointing, however, is the report’s almost exclusive focus on medicines. NICE guidance goes far beyond evaluation of medicines, with clinical guidelines and public health guidance presenting real opportunities to reduce health inequalities. We would suggest that work is done urgently to better understand the issues around implementation of guidelines and public health guidance.

4. QUALITY AND OUTCOMES FRAMEWORK (QOF)

4.1 As indicated by the work described above, the QOF is a major driver in changing clinical behaviour in primary care. It has already gone some way to improving focus on identification and management of patients in priority health areas, such as heart disease and diabetes, which tend to affect those in disadvantaged communities most. More needs to be done to focus the QOF on targeting activity at those at highest risk of disease.

4.2 The QOF should also be used to incentivise implementation of NICE guidance. There seems little logic to a situation where two initiatives designed to improve the quality and equity of NHS care are not linked.

5. PAY FOR PERFORMANCE/PAYMENT FOR QUALITY

5.1 The QOF relates to activity in primary care. One of the future options in secondary care to improve the quality and consistency of services, discussed in the context of Payment by Results, is to introduce direct financial incentives for provider Trusts, and a pilot scheme is currently being prepared by NHS North West. It draws inspiration from a major “pay for performance” scheme operating in the US and is planned to be introduced in the North West in 2008–09. Under the proposal, all provider Trusts in the region would submit auditable quality data based on pre-specified measures. The best X% (e.g. 10%) of providers would then receive a 2% uplift to the PbR revenues they receive. The next best Y% of providers (e.g. the second decile)

would receive a 1% uplift. All other providers—the majority—would receive only the tariff price. This idea is presented favourably in the Department of Health consultation document on Payment by Results of March 2007:

“We see considerable potential in adopting a “pay for performance” type approach in England, to operate alongside, and complementary to, the national tariff.” (para. 3.27)

5.2 The ABPI believes that this initiative should be encouraged and used more widely to increase standards of care in the hospital environment, including appropriate use of medicines. Payment for Quality and other such incentives should also be aligned with implementation of NICE guidance.

6. INEQUALITIES CREATED BY PUBLIC POLICY

6.1 One consequence of a focus on major public health issues is that diseases and therapies that do not fall within these priorities receive less attention, thus creating inequalities. This is a general area of concern to the ABPI, but is particularly manifest in the management of orphan conditions and access to medicines for these conditions.

6.2 Specialist treatments in the UK may pose funding difficulties at local PCT level, particularly where there are no national recommendations, such as from NICE, because the treatment has not been referred for assessment owing to its low total budget impact, or where there is a delay in the recommendation being made. In addition, few orphan diseases have a national clinical guideline from a professional body to inform commissioning.

Two issues exist in the way that orphan medicines are commissioned:

- Only treatments for extremely rare diseases (unlikely to be over 400 patients for a particular disease in the whole of the UK) are commissioned nationally by the National Commissioning Group (NCG). The budget is held centrally and specific providers are designated to provide these services for a national caseload. The funding of very rare diseases by the NCG is primarily about service and infrastructure and medicines may not be funded.
- The 10 Specialist Commissioning Groups that commission specialised services at a regional level are still in development and local commissioning for orphan medicines is often left to the local PCT to make decisions. These medicines are therefore subject to case-by-case decisions, a system which is inefficient in terms of NHS time and leads to many patients being denied the treatment they need.

6.3 The ABPI believes commissioning decisions for orphan medicines should be included in the remit of the 10 regional SCGs. PCTs cannot predict the likelihood of occurrence of a rare disease which does not present evenly across local geographies, making it difficult to assign budgets at PCT level.

6.4 Health Technology Assessment for orphan medicines is problematic. Because of the rarity of the conditions under examination, the consequent paucity of natural history data, generally poorly validated clinical end-points and low patient numbers in trials, there is likely to be a relatively high level of uncertainty around some aspects of the evidence, including long-term outcomes and cost effectiveness, at time of launch. Orphan medicines by definition are indicated to treat serious, life threatening or chronically debilitating diseases for which no satisfactory treatment exists. For these reasons, the ABPI believes that orphan medicines should be exempted from standard HTA processes. Where HTA processes are applied, cost per QALY “modifiers” should be applied, so that equity and societal preferences are taken into consideration as well as economic efficiency. These modifiers should include severity of disease, unmet need (innovation), clinical effectiveness and overall budget impact.

7. INDUSTRY SUPPORT FOR REDUCING HEALTH INEQUALITIES

7.1 Pharmaceutical companies are working with a number of NHS organisations on “find and treat” strategies, whereby people with diseases of priority to the locality, who are often difficult to reach, are identified for appropriate treatment and management. This “joint working” is where the pharmaceutical industry and NHS organisations pool skills, experience and/or resources for the joint development and implementation of projects for the benefit of patients and share a commitment to successful delivery. Joint working agreements and management arrangements are conducted collaboratively in an open and transparent manner with appropriate governance arrangements. Joint working differs from sponsorship, where pharmaceutical companies simply provide funds for specific events or work programmes.

7.2 Examples of successful joint working that support the tackling of health inequalities are growing rapidly, and as part of the work commissioned by the MISG described above, DH guidance and a “best practice toolkit” will be launched to the NHS and industry in the spring of this year.

Memorandum by MODEL (HI 94)

HEALTH INEQUALITIES

EXECUTIVE SUMMARY AND RECOMMENDATIONS

The MODEL (Management of Diabetes for Excellence) Group is a group of health professionals with a wide range of knowledge and experience in the care of diabetes that advocates excellence as the only effective response to what is a chronic epidemic in diabetes, and brings a professional perspective on the current state of diabetes care and its future direction.⁷⁰⁸ This submission focuses on health inequalities in diabetes.

Diabetes is a complex, insidious, long-term condition, marked by serious health inequalities, that requires multiple interventions and care services. The number of people affected by diabetes is growing at such an alarming rate that it threatens to overwhelm the health service. Diabetes particularly affects deprived, aged, and black and minority ethnic (BME) populations. Children with diabetes need specialist care. Quality and access to diabetes care vary significantly.

Excellent diabetes care will go a long way to addressing important health inequalities. The diabetes epidemic can be slowed down and health inequalities addressed if the balance of care shifts from treatment of expensive and avoidable complications to targeted prevention and intensive management of blood sugar, blood lipids and blood pressure. Multi-stakeholder approaches have been seen to work, involving the health service, industry, food producers/retailers, schools/universities, social services and architects/town planners. Special measures are required for deprived and difficult-to-reach populations. The current quality of care for children is grossly inadequate and DH/Diabetes UK recommendations for improvements should be fully implemented (and funded).

Diabetes is well served to address these challenges, backed as it is by a National Service Framework, NICE guidance, QOF, robust epidemiological data, diabetes networks supported by the National Diabetes Support Team, validated and cost-effective structured education programmes, and a toolkit for commissioners. However, frequent organisational change, short-term budget pressures, unintended consequences of moving care closer to home, poor inter-agency communication, often exacerbated by competitive rather than collaborative behaviour, fragmentation of provider services, and deficiencies in commissioning knowledge and skills are preventing local agencies from bringing these together into a cohesive package.

Strong commissioning and multi-agency working are critical. Diabetes Networks are best placed to ensure that local agencies work together and that resources are deployed effectively.

RECOMMENDATIONS:

- Diabetes Networks are given the authority and resources to bring NHS purchasers and providers, public health officials and community stakeholders together to develop joint needs assessments, plans and care pathways.
- The recommendations of the report, “Making Every Young Person with Diabetes Matter”, are implemented as a matter of urgency.
- Diabetes is given priority in “testing” implementation of the new Commissioning Framework piecing together the jigsaw of major policies, national guidelines and support tools that already exist into a cohesive package to deliver high-quality and cost-effective care.
- The potential of Practice Based Commissioning to improve the quality and consistency of diabetes care is fully realised.

1. INTRODUCTION

1.1 The MODEL Group was launched on 17th May 2007 and has made two important contributions to the debate on diabetes care:

- The MODEL Report, which represents the views of the Group on diabetes care in England and Wales and provides a holistic assessment of the current and future state of diabetes care and a vision for the future. The report was compiled on the basis of desk research, a series of roundtable discussions between group members, and interviews with 26 expert witnesses.
- A MODEL for Excellence: setting out the Group’s vision for better diabetes care (Appendix 1).

⁷⁰⁸ The MODEL Group—Prof David Matthews (Chairman), Prof Melanie Davies, Dr Clare Davison, Prof David Dunger, Eileen Emptage, Prof Stephen Gough, Christine Hancock, Prof David Russell-Jones, Grace Vanterpool.

1.2 The MODEL Group welcomes this Inquiry into a highly important aspect of healthcare delivery in England, as diabetes is characterised by substantial health and social inequalities.

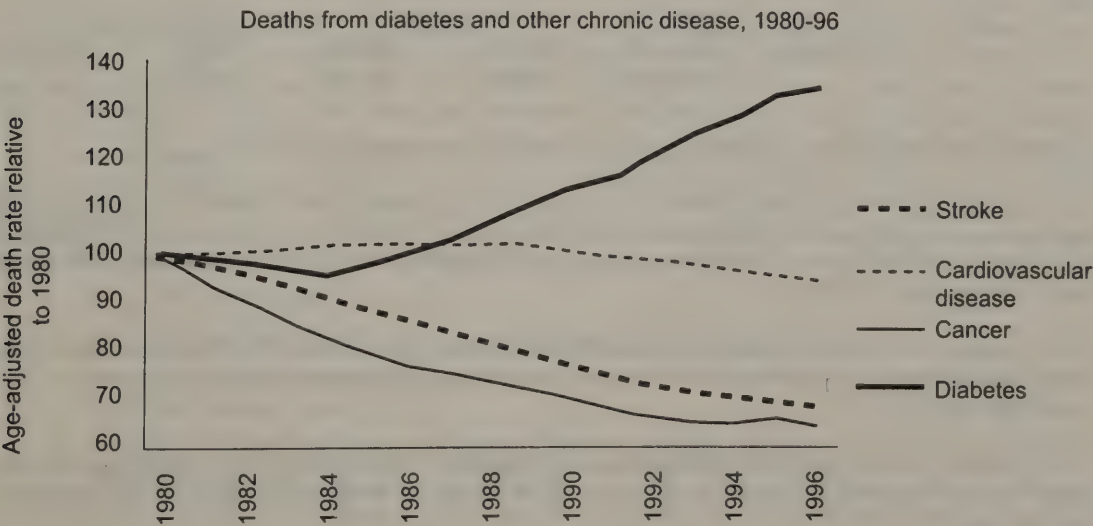
2. DIABETES

2.1 Diabetes is a chronic disease where blood glucose is too high, either because insulin is not produced or is insufficient. Type 1 diabetes occurs when the body is unable to produce any insulin and can happen at any age. In Type 2 diabetes, the islets of Langerhans in the pancreas do not make enough insulin and the insulin action is often reduced; it is more common in those over 40 and with a family history.

2.2 The number of people affected by diabetes is growing at a rate that threatens to overwhelm the health service. One in 25 people in England and Wales has diabetes, the equivalent of at least one child in every school class developing the disease. Diabetes costs 10% of NHS spending. By 2010, the number of people with diabetes in England will reach 2.5 million and costs will rise by 25% by 2040. Perhaps up to one third of people with diabetes have not been diagnosed.

- 2.3 The complications arising from diabetes can be devastating:
- Diabetes increases the risk of major medical complications 11-fold
 - Diabetes increases the need for hospital admission 5-fold
 - Diabetes reduces average life expectancy: Type 1 by 15–20 years and Type 2 by at least five years
 - Half of those with diabetes die from a diabetes-related condition

Complication	Risk
Heart attack	3 times as likely
Heart disease	4 times as likely
Stroke	4 times as likely
Amputation	15% develop foot ulcers 15% of these need amputation
Total kidney failure	3 times as likely
Blindness	30% Type II patients have renal disease
Depression	Single largest cause of new cases of adult blindness 2 times as likely 1/3 has significant depressive symptoms



Source: National Centre for Health Statistics 1998.

2.4 These complications are not only devastating for the patient, they are also very costly: more than 50% of expenditure on diabetes care arises from the management of complications, half of which can be avoided.

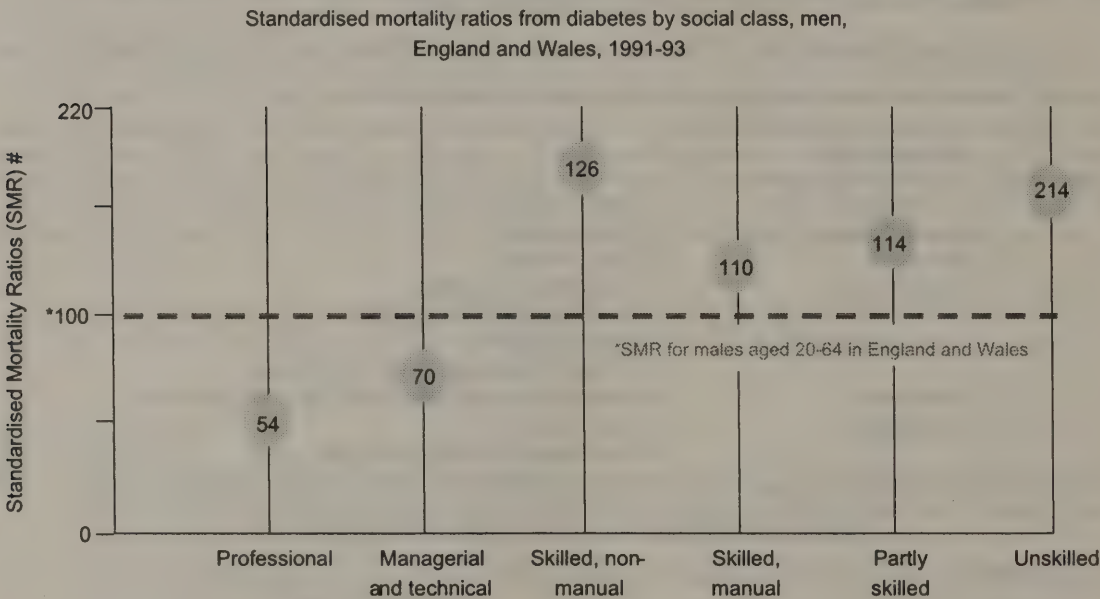
2.5 A key characteristic of diabetes is its continually changing nature as the patient progresses through life and the disease. Whereas in some long-term conditions, eg hypertension, simple lifestyle and pharmacological intervention can sustain control in the long term, diabetes changes subtly and insidiously even in patients who are well managed. This means that the health system has to work continually with the patient to manage the disease according to his/her particular circumstances in order to prevent unnecessary and costly complications.

3. HEALTH INEQUALITIES IN DIABETES

3.1 Diabetes is marked by substantial and important inequalities.

3.2 Deprivation: both the symptoms of diabetes and risk of death are increased in more deprived populations, including the unemployed and those with less education⁷⁰⁹. GP registration suggests that diabetes incidence in the most deprived areas is two-thirds higher than in the most affluent. While diabetes is increasing in all areas, the rate of increase is greatest in deprived areas.

Standardised mortality ratios from diabetes by social class, men, England and Wales, 1991–93



Source: National Statistics: Health Inequalities decennial supplement 1997 (1–9).

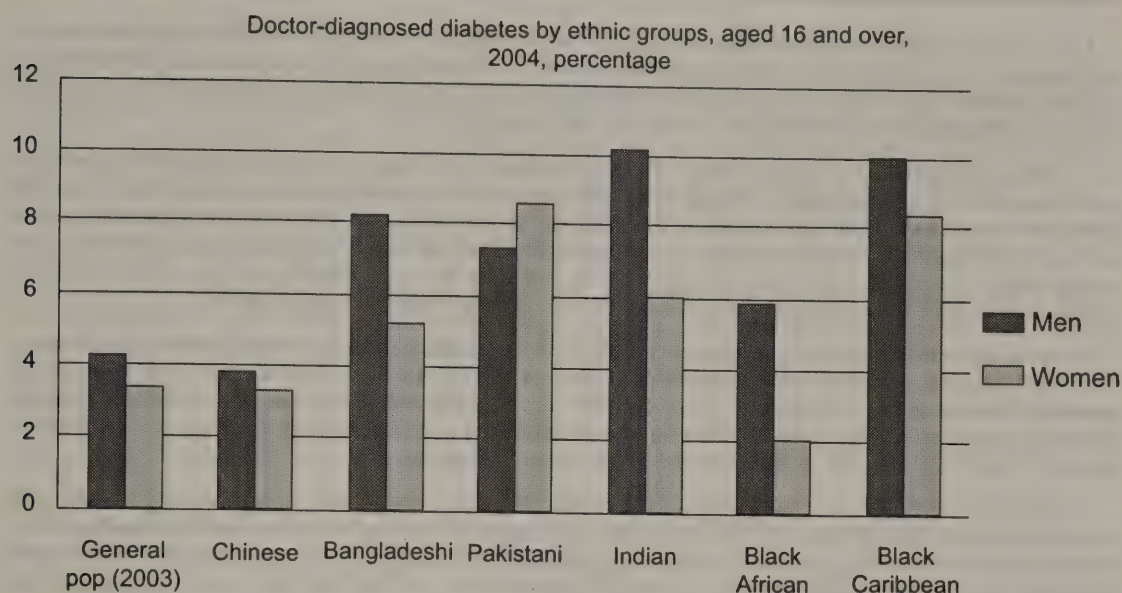
£ Standardised mortality ratios (SMRs) are used to compare death rates in different segments of the population, taking into account differences in their composition. The SMR for males aged 20–64 in England and Wales is 100. SMRs below 100 indicate lower mortality than expected. SMRs greater than 100 indicate higher than average mortality.

3.3 Ageing: diabetes prevalence increases dramatically with age, from 0.33% of the population under 30 to 13.8% of those over 60. The prevalence of diabetes in nursing homes is up to 25% compared to 3% in the general population⁷¹⁰.

3.4 Ethnicity: people from BME populations are particularly susceptible to Type 2 diabetes, especially those with an Asian or Afro-Caribbean background. Diabetes also develops some ten years earlier than in European populations.

⁷⁰⁹ Yorkshire and Humber Public Health Observatory (2005): PBS Diabetes Population Prevalence Model Phase 2. www.yhpho.org.uk/viewResource.aspx?id=71

⁷¹⁰ Diabetes UK: Diabetes and the disadvantaged: reducing health inequalities in the UK. A report by the All Parliamentary Group for Diabetes and Diabetes UK. World Diabetes Day. 14 November 2006.



Source: Health Survey for England 2004. The Health of Minority Ethnic Groups (1–7).

3.5 Children: diabetes has a devastating effect on children who are the most under-served group. The incidence of Type 2 diabetes in children is increasing at an unprecedented rate and there are concerns that incidence will rise significantly in the next 10 years.

3.6 Other disadvantaged groups: people with severe mental illness, learning difficulties, the homeless, prisoners, travellers, refugees and asylum seekers are at higher risk of ill-health and may have poorer access to the health system.

3.7 Obesity is the single most important predictor of diabetes, although lack of exercise, poor diet and smoking are all associated with increased risk. The risk of Type 2 diabetes is almost 13 times greater in obese women as in women of normal weight; or five times greater in men. In 2001, about half of Type 2 cases in England were estimated to be related to overweight.

3.8 Deprivation is strongly associated with higher levels of obesity, physical inactivity, unhealthy diet, and smoking, with a 50% greater likelihood of smoking in lower socio-economic groups, and less likelihood of access to a healthy balanced diet and facilities for physical activity.

4. WHAT CAN THE NHS AND OTHER AGENCIES DO?

4.1 Excellent diabetes care would go a long way to addressing important health inequalities. Type 2 diabetes is preventable, as are many diabetes complications. The key to cost effective care is active investment in targeted prevention and intensive management of blood glucose, blood lipids and blood pressure, and supporting people with diabetes to fit diabetes to their lives not their lives to diabetes. Unfortunately, the NHS is focused on expensive treatment and management of avoidable complications.

4.2 The complexity of diabetes and its multiple complications means that patients need multiple interventions—medical, psychological, behavioural, social, familial—delivered by a wide range of health professionals.

4.3 The following are the key elements of care:

- Early identification and diagnosis
- Prevention strategies targeted at high-risk groups (see Appendix 2)
- Multiple medical options aimed at retaining a normal life, including a balanced primary and specialist care provision
- Actively engaged and informed patients able to manage their condition and to take their medication correctly
- Structured educational support for people with diabetes and their families
- Psychological support to help change lifestyle and behaviour and overcome the difficulties of stressful transition periods
- Extra and separate specialist care for children and young people
- Support in pregnancy

4.4 The multi-faceted nature of the risks for developing diabetes requires concerted action not only by the health system. Political and communal will is required, involving industry, business, food producers and retailers, schools and universities, social services, architects and town planners. Experience in Finland shows that a multi-stakeholder approach can work (see Appendix 2).

4.5 Once diabetes has developed, addressing inequalities also requires special targeted measures for particular, high-risk populations. People from deprived or ethnic communities are less likely to access appropriate care, have their body mass index or smoking status recorded or have records for blood glucose, retinal screening, and blood pressure. They may be difficult to reach via mainstream channels, face inequalities in accessing care, be constrained by language or literacy difficulties or by culture, religious beliefs, and lifestyle. Many good examples exist of such targeted measures (see Appendix 3).

4.6 Previous work on diabetes services means that much is in place to address these challenges. There are evidence-based national standards in the form of the National Service Framework and 13 pieces of NICE guidance. Robust data are available on prevalence from the Public Health Observatory, Brent, SchARR Model and on people registered with diabetes under the Quality and Outcomes Framework (QOF). Ninety-three of the 655 QOF points in the clinical domain relate to diabetes.

4.7 Resource has been specifically allocated to help design and configure services according to local need through the formation of about 150 diabetes networks supported by the National Diabetes Support Team. Commissioners have been supported through the publication of a Diabetes Commissioning Toolkit, which describes how to carry out a diabetes health needs assessment, specifies diabetes care, and suggests key outcomes for services.

4.8 In recognition of the need for structured education for people with diabetes, as advocated in NICE guidance, two national programmes have been developed: Dose Adjustment for Normal Eating (DAFNE) for Type 1, and Diabetes Education and Self-Management for Ongoing and Newly-Diagnosed (DESMOND) for Type 2. DAFNE has been shown to cover its own costs in about four years⁷¹¹, and a randomised controlled trial will report on DESMOND in 2008. The “year of care” approach, enabling people with diabetes to exercise choice in the design of a package to meet their individual needs, is being piloted in diabetes.

4.9 Commissioners and providers are therefore well supported by this “jigsaw” of initiatives and policies.

5. INEQUALITIES IN NHS CARE

5.1 Health inequalities in diabetes do not only arise from variable risk but from inequalities in care quality and delivery. The Healthcare Commission found that the QOF scores for practices in poorer areas tend to be lower than those for richer areas, especially in single-handed practices⁷¹². In Eastern Leicester, which is a poor area, where half the population is South Asian, and where there are a high number of single-handed practices, only 10% of practices offered any structured education, and 76% were unable to produce a practice protocol for diabetes. Inadequate training, access to nurse hours and dietitian support were also evident⁷¹³.

5.2 Access to a dietitian varies considerably across the country. All diabetes patients should ideally have advice from a specialist dietitian within four weeks of diagnosis but some 70% do not, and less than half of the dietitians offer an annual review. Waiting times for direct access to hospital dietitians range from 5 weeks to 27 weeks. Also the quality of dietetic advice appears to vary significantly⁷¹⁴. ⁷¹⁵. Concern has been expressed about the training of other health professionals and peer educators to deliver consistently high quality dietary advice⁷¹⁶. Access to personalised advice on exercise is even rarer than dietary advice.

5.3 NICE guidance recommends that structured education be undertaken at the time of diagnosis and beyond, based upon formal assessment of need, but notes that the length, content and style of education varies considerably. Validated programmes such as DAFNE and DESMOND are not available in substantial areas of England for geographical or financial reasons despite their proven cost-effectiveness. The DH/DUK Patient Education Working Group identified a number of areas lacking adequate provision, including children/adolescents and BME groups.

5.4 A diabetes diagnosis is often associated with depression. Families need help too. The NHS provides no psychological support to families, or information to employers and friends.

⁷¹¹ Loveman, E., C. Cave, C. Green, P. Royle, N. Dunn, N. Waugh (2003): The clinical and cost-effectiveness of patient education models for diabetes: a systematic review and economic evaluation. NHS R&D Health Technology Assessment Programme 7, No 22.

⁷¹² Healthcare Commission (2006): State of Healthcare 2006.

⁷¹³ NHS National Diabetes Support Team (2006): Primary care commissioning factsheet.

⁷¹⁴ Nelson, M, Lean, M. E. J., Connor, H., Thomas, B. J., Lord, K., Hartland, B., Waldron, S., McGough, N., Walker, L., Ryan, A. & Start, K. (2000): Survey of dietetic provision for patients with diabetes. *Diabetic Medicine* 17, 565.

⁷¹⁵ Dyson, P. (2006): OCDEM: expert witness to MODEL Group.

⁷¹⁶ Blackledge, H. and J. Belza (2003): Health Needs Assessment for People with Diabetes in Leicester, Leicestershire and Rutland.

6. CHILDREN

6.1 Inequalities and deficiencies in care for children with diabetes are of such concern to the DH that it commissioned a Children and Young People's Diabetes Services working group which reported in 2007. Children need care from specialist units. They have particular needs for education and psychological support, and their families also need help. Yet care is grossly inadequate. According to the National Diabetes Audit 2006⁷¹⁷, the proportion of children and young people receiving all the care processes they should was only 2%, and only 54% of PCTs had guidelines for the management of children and young people. Psychological and psychiatric support is highly variable with waiting times as long as 18 months.

6.2 "Making Every Young Person with Diabetes Matter" came up with a comprehensive list of recommendations to coordinate services via regional networks, appropriately managed and able to audit services and provide some regional support for pump therapy and complex cases. Although care would continue to be delivered as close as possible to the patient's home it would be coordinated and equitable across the region. Such regional solutions require several PCTs to come together, perhaps under the aegis of the SHA, and ultimately some degree of top slicing of PCT funds. It is vital that the report's recommendations are implemented.

Proportion of children and young people receiving care processes (% of patients of 12–15 years, 2003–4)

<i>Care process</i>	<i>Males</i>	<i>Females</i>
HbA1c	80	81
BMI	53	56
Blood pressure	46	48
Urinary albumin	20	21
Creatine	21	23
Cholesterol	19	18
Eye examination	19	19
Foot examination	17	20
All care processes	2	2

Source: National Diabetes Audit (2006) (3–2).

7. BARRIERS TO IMPROVING EQUALITY

7.1 Achievement of excellent care in diabetes would play a significant part in reducing health inequalities, alongside special measures for deprived and hard-to-reach groups. However, there are a number of factors that the MODEL Group believes mitigate against the NHS's ability to deliver this care.

7.2 Short Term Pressures: diabetes is a long-term condition, but short-term pressures, much of which are driven by attempts to "balance the books", are leading to a dismantling of high quality services that will be hard to replace and increase inequalities. For example:

- Diabetes nurses are losing their jobs
- Training budgets are being cut—both for professionals and patients
- The priority given to public health and programmes to prevent disease and promote healthy lifestyles is being reduced

One of the threats of a growing epidemic is that funding streams may not increase in proportion to the size of the problem or funding is diverted to fulfil short term aims and financial balance.

7.3 Moving Care Closer to Home: there is value in moving as much care as possible into primary care. However, in order to achieve this in a way that delivers safe and high-quality care, primary care professionals have to be adequately trained and resourced. We are concerned that the shift is taking place without ensuring that the necessary training and expertise are in place. The shift has resulted in some PCTs downsizing specialist diabetes units at a time when numbers of people with diabetes are growing at an alarming rate and the need for specialist expertise to manage complex cases is increasing.

7.4 Fragmentation: whilst we recognise that capacity increases are necessary and that in some areas a plurality of providers may be a solution, the imposition of new providers, who can be in competition with one another, into local health economies is leading to fragmentation of services that does little to support "seamless care" or safety. Emphasis needs to be given to working with Practice Based Commissioning Groups to ensure that services commissioned address this issue. Diabetes network meetings are often managed by commissioners and may be convened only to dispense information rather than receive opinions. This could be improved by appointing local expert leads/chairs.

⁷¹⁷ National Diabetes Audit (2006): Key findings about the quality of care for children and young people with diabetes in England incorporating registrations from Wales. Report for the audit period 2004–05.

7.5 Communication: without effective communication there is little hope for the delivery of equitable care. We do not believe that IT systems are fit for purpose or will be in the near future. Communication, in the absence of good IT systems, relies on active cooperation between organisations and departments, and in many areas, competition rather than collaborative behaviour is the norm—hospital against hospital and specialist against primary services—that is destructive. We advocate investment into local information exchange—a relatively cheap option where the benefits are immediately apparent and where the technology generally exists. Waiting for an all embracing solution is now inappropriate.

7.6 QOF: the QOF has undoubtedly helped to ensure that people with diabetes are properly registered and checked by their local practice, but QOF only requires assurance that checks have been made, not that quality is assured or a holistic approach taken. It is known that some people with diabetes are being required to visit their practices more than 10 times a year in order to fulfil QOF checks—an unstructured approach to diabetes care that is contrary to that advocated by the Royal College of General Practitioners since 1994. QOF is also blazoned on its own website as a mechanism for adjusting GP income—a financial process rather than a care package.

7.7 Skilled and Resourced Commissioners: commissioners are key to addressing health inequalities in diabetes but this requires that they have adequate knowledge, skills and resources. The commissioning function needs to be mature enough to consult and achieve the commitment of providers to design and implement structured care pathways. Gaining local consensus requires active facilitation and management. Practice based commissioning may have the effect of stimulating preventative care and developing better care for diabetes. Early evidence is promising.

January 2008

Appendix 1

The MODEL Group's MODEL for Excellence in Diabetes Care

PROFESSIONAL EXCELLENCE

- Healthcare professionals with competence and confidence in managing people with diabetes throughout the progress of their disease
- GPs with time and expertise providing a large volume of care to large numbers of patients, based on a sound knowledge of local needs of the community and insight into personal needs
- Specialist diabetologists in centres of excellence supported by specialist nurses and a multi-disciplinary team providing expert input to model care development, continuous support for patients in high clinical need or in periods of transition, and emergency support in complicated cases
- Support by healthcare professionals for intermediate care if this is in line with local needs

COMMUNICATIONS EXCELLENCE

- Active, informed patients participating as partners in managing care resources
- A mechanism for all healthcare providers and users to communicate with each other, through existing IT with appropriate interconnectivity and local diabetes networks appropriately convened and managed.

We believe the following measures need to be taken:

DIAGNOSIS AND MONITORING

- Intensive management of blood glucose, blood lipids and blood pressure
- Evidence-based treatment according to the needs and events in the life of the person with diabetes
- Integrated and evidence-based multiple interventions: medical, psychological, behavioural, social, familial
- Regular monitoring of clinical indicators, allocating enough time to discuss patients' concerns, plus surveillance for early signs of complications

SUPPORT FOR PEOPLE WITH DIABETES:

- Provision of lifestyle advice, especially to those at high risk
- Excellent information for people with diabetes, their families and carers, and provision of structured education
- Psychosocial support when needed

A SEAMLESS SYSTEM:

- Patients progressing seamlessly between primary and secondary diabetes care, and back to primary care if possible
- Seamless referral to specialists in other disciplines, eg cardiovascular, renal
- Seamless flow of patient information to all members of the multi-disciplinary team

Key to the delivery of the MODEL for excellence is good collaborative working between all the agencies involved in diabetes care.

Appendix 2**The Finnish Diabetes Prevention Study**

The Finnish programme for the prevention of Type 2 diabetes is a great example of addressing multiple complications and is the first national level programme of its kind in the world. At least a third of Finns have a genetic predisposition to developing Type 2 diabetes, and 10–20% have impaired glucose tolerance. The programme is based on the experience gained in the Finnish Diabetes Prevention Study, which involved over 500 overweight, middle-aged men at high risk of diabetes. After four years, those given a better diet and increased physical activity showed more than a 50% reduction in diabetes incidence. The whole concept of health promotion was pioneered in Finland in the 1970s and is well established at the municipal level.

The prevention programme, which builds on this initial experience, has three concurrent strands. The Population Strategy aims to promote the health of the whole population, by means of nutritional guidance and increased physical activity so that the risk factors for Type 2 diabetes, such as obesity and metabolic syndrome, are reduced in all age groups.

This is coupled with the High-Risk Strategy which uses individually-designed measures to target people with a particularly high risk of developing Type 2 diabetes, including screening, education and monitoring.

The third strand is the Strategy of Early Diagnosis and Management directed towards newly-diagnosed Type 2 patients and designed to bring them into systematic treatment to prevent the development of expensive diabetic complications. It includes practical instructions for intensive lifestyle management.

Importantly, putting this multi-pronged programme into action involves improvement of the Finnish healthcare system and restructuring of health promotion activities, plus the services of non-governmental organisations involved in public health, nutrition and physical education. Cooperation under the Population Strategy encompasses the entire range of Finnish non-governmental organisations as well as participants from the business community and the education sectors. The feasibility and cost-effectiveness of the prevention programme is being assessed in four hospital districts between 2003–7. Training and materials related to the prevention programme have been made available throughout the country. The results available so far show an impressive confirmation of the feasibility of such a multi-stakeholder approach.

Appendix 3**Good Examples of Targeting High Risk or Difficult to Reach Groups****SLOUGH**

Diabetes specialist nurse Grace Vanterpool used Dr Foster software to gather information about the location of Asian businesses and homes in Slough. This enabled her Health Activist team to pinpoint the best locations to offer health information. They took a highly visible double-decker bus to key places frequented by the Pakistani people in Slough, including supermarkets, community centres, leisure centres, and mosques—and enlisted the support of lay community leaders. Key points about risk factors for diabetes could then be passed on to a large number of people through these well-known and trusted people. Visitors to the bus were given information, the chance to ask questions, and offered pinprick testing for blood glucose. As a result of the initiative the level of diagnosed diabetes in the Slough population doubled⁷¹⁸.

NORWICH

An initiative in Norwich shows how preventive steps toward obese children and young people can become the focus of a multiple stakeholder initiative reaching beyond the healthcare system to enlist the support of other elements in the community. The Nutrifyt Kidz Club in Norwich is a charitable programme run by North Earlham, Larkman and Marlpit Development Trust, the Norfolk Sports Alliance and the Football in the Community team at Carrow Park. Free of charge, it offers up to 80 young people the chance to exercise, and also build self esteem and a greater knowledge and appreciation of food and health. Young

⁷¹⁸ Vanterpool, G. (2006): MODEL Group evidence.

people with weight problems are referred to the club by dietitians, GPs and consultants at the Norfolk and Norwich Hospitals. One in four of Norfolk's population under 15 years (15,700) is overweight, and a third of these (5,700) are obese; giving rise to medical costs of up to £40m a year⁷¹⁹.

MEND (MIND, EXERCISE, NUTRITION—Do it!)

The MEND (Mind, Exercise, Nutrition—Do it!) programme is a countrywide initiative with local activities for families with overweight or obese children. Its mission is to educate, motivate and transform children and families to change their unhealthy habits to ones that support a healthier lifestyle, and to ensure sustained health for the whole family⁷²⁰.

LEICESTER

Leicester, with its high South Asian population, is a particular centre for diabetes research and related healthcare initiatives. Project Dil, for example, is a coordinated primary care and health promotion programme aimed at reducing the risk factors for coronary heart disease in the South Asian community. It has used a training and awareness programme for healthcare professionals, organisational changes to develop an effective secondary prevention programme in general practice, and a public awareness programme. Leicester University Hospitals NHS Trust is also one of the 21 universities, hospitals and medical centres participating in the Europe-wide project called Diabetes in Europe—Prevention using lifestyle, physical activity and nutritional intervention (DE-PLAN), which is funded by the EU under its public health programme. This initiative aims to build on the results of the Finnish diabetes prevention study by assessing the risk of Type 2 diabetes in European populations and to develop and evaluate a lifestyle intervention programme to prevent its incidence in high-risk individuals⁷²¹.

NEWHAM

Newham in London has about 14,000 diagnosed diabetes patients but a suspected further 5,000 who are not even registered with GPs. A new public health initiative aims to identify as many people as possible who may be at risk of diabetes in the community, and encourage them to register, when they can begin proper assessment and treatment. Newham's Communities of Health initiative is building on the many natural social groups in Newham, eg Somali women's cultural groups or South Asian men's groups. The health messages can "piggyback" on the activities of these groups; and special events, on hypertension or diabetes for example, can be held to deliver specific information. Those identified as being at high risk can be given letters to GPs and follow-up can often be shared with the community group leaders. Newham is also encouraging the involvement of pharmacists, who are well placed to identify people at high risk of diabetes and are able to offer advice or even tests for blood glucose. Again, those identified can be referred to a GP. The two approaches also have a secondary impact in the awareness they create in the community⁷²².

HULL

Hull has a population of predominantly white people with a high level of unemployment and, at 6–7%, a relatively high prevalence of diabetes. Its programme to improve the situation is well under way and includes both primary and secondary prevention measures. Raising awareness in the general public about diet, exercise and diabetes is being addressed by a variety of means including talks in schools, health promotion DVDs shown in pharmacies and public advertising screens, podcasts prepared by a dietitian and open days and other awareness events. For those who have had diabetes diagnosed, care is much more focused in GPs' surgeries than formerly and the improvement programme provides extra training for GPs and practice nurses, to expand their detailed knowledge of diabetes so they can encourage better self-management. Diabetes consultants are now regularly working alongside GPs in their clinics and also conducting case reviews to advise on patient care and develop the skills of the primary sector⁷²³.

WALES

In Wales the Inequalities in Health Fund was set up in 2001 to support local action to address differences in access to health services. It supports over 60 projects in disadvantaged communities through joint action by the NHS, local authorities and the voluntary sector. Some examples of projects relating to diabetes prevention are in Pembrokeshire, where screening, nutrition and lifestyle change advice had helped well over

⁷¹⁹ Thalange, N. (2006): expert witness to MODEL Group.

⁷²⁰ The MEND Programme (2006): <http://www.mendprogramme.org/>

⁷²¹ Davies, M. (2006): MODEL Group evidence.

⁷²² Elkheir, R. (2006): expert witness to MODEL Group.

⁷²³ Bowker, P. (2007): expert witness to MODEL Group.

6,000 people by the end of 2005, with clinics held in the evenings and at weekends to be more accessible to working people. In Merthyr Tydfil are the Diabetes Peer Support Programme and one on promoting health in small workplaces⁷²⁴.

Memorandum by the Mayor of London (HI 95)

THE CONTRIBUTION OF THE NHS TO REDUCING HEALTH INEQUALITIES

SUMMARY

- The Mayor of London welcomes the opportunity to submit this written response to the Health Committee Inquiry into the contribution of the NHS to reducing health inequalities. In addition, he welcomes this government's focus on health inequalities as an issue which requires commitment and action from government departments, regional and local government, the health service and a range of other sectors and organisations.
- The Mayor is concerned about inequalities between communities of place and those between communities of identity or interest. The impact of health inequalities on Londoners are described elsewhere. This submission is intended to supplement previously published evidence and research. Based on evidence, the Mayor is of the view that action to reduce health inequalities must focus on people living in deprived areas and those affected by relative poverty, as well as working with people disadvantaged by social exclusion, stigma or discrimination.
- It is informed by preparatory work for the Mayor's Health Inequalities Strategy which included a Call for Evidence and an Outreach initiative, generating formal responses from more than 100 community groups and providing deeper insight into the factors affecting the health of London's more excluded communities. In addition, this submission reflects the priorities of a wide range of stakeholders—the London Health Commission, academics, NHS and public health practitioners, policy-makers, local government, community groups and employers—for strategic action to reduce health inequalities.
- This inquiry is taking place at the same time as the Government is extending the Mayor's powers to include a new duty to promote a reduction in health inequalities in London and publish a statutory health inequalities strategy. In addition it coincides with consultation on NHS London's *Healthcare for London*. The Mayor considers it essential that proposals and action on these two strategic plans are aligned in order to achieve the maximum impact on the entrenched health inequalities that exist in London.
- Reducing health inequalities must be a particular priority for NHS London, and the Mayor believes the NHS has a key contribution to make in each of the policy areas emerging as priorities for the London Health Inequalities Strategy, summarised below. In addition, the NHS has an ongoing role in supporting the development and delivery of the Mayor's strategies and programmes in a wide range of related areas, including those on economic development, spatial planning, environment issues, climate change, housing, and skills.
- The submission summarises the Mayor's view about ways in which the NHS can contribute to reducing health inequalities both in its core role as a health service provider and in its broader role as an employer and corporate citizen. Additional evidence and information underpinning this summary is available on the Greater London Authority website.

INTRODUCTION

1. Average life expectancy continues to increase across the UK, and the outcomes for many individuals facing a range of health problems continue to improve, with the NHS having a central role in achieving this progress. However, an ongoing challenge facing health policy-makers and service providers is to ensure that those people who are most disadvantaged in health terms are benefiting most so as to reduce health inequalities as well as improving "average" population health.

2. In addition, a key challenge for the NHS is to place more emphasis on its potential impact on a wide range of social determinants of health through its role as an employer, procurer of goods and services, and estate manager. The health service can and should make a significant contribution to action on each of the emerging priorities for the Mayor's Health Inequalities Strategy which relate to income and employment, healthy places, individual and community participation, public service provision, and the continued building and application of evidence.

⁷²⁴ Welsh Assembly Government (2005): *Inequalities in Health: The Welsh dimension 2002–2005*.

THE NHS'S ROLE AS A SERVICE PROVIDER

3. Access to effective health care, as well as social care and a range of other public services, can both prevent people becoming ill and help them recover when they do. Yet geographical variations in the provision of health services within London mean that some Londoners have better access to treatment and preventative services than others. Unequal access to health care information and services and differences in the quality of health care provision can both contribute to health inequalities and exacerbate existing disadvantage and exclusion.

4. The Mayor believes that the NHS should aspire to provide world-class health services to all their patients from all of their healthcare facilities. He considers the NHS must be world class not only at the level of hi-tech surgical or medical treatments and research, but also in the provision of community health services and preventative services, and in the contribution health services make to reducing inequalities.

5. The Mayor is concerned about the vulnerability of NHS funding for public health and preventative interventions, as illustrated by recent concerns about funding for sexual health promotion and HIV prevention in London. Similarly, he is currently discussing with government and other partners his concerns about the lack of clarity and certainty about arrangements for funding programmes to promote physical activity. Although the NHS is not the only sector to which this applies, it is important they continue to contribute to relevant initiatives to increase activity levels as part of a sustained effort to reduce future illness and premature death.

6. In response to previous Government consultations, the Mayor has emphasised key service-related issues he believes the NHS should address to improve the health of all Londoners, all of which are relevant to this Inquiry and include the need for:

- significant and sustained investment and focus on prevention and health promotion within all care settings and across all NHS activity;
- increased focus on supporting people to improve both their physical and mental well-being and to maintain or regain their independence;
- proactive identification and planning to meet the particular needs of newly arrived, highly mobile, and excluded groups;
- effective integrated health planning for new population growth, including investment in health and social infrastructure;
- development and delivery of increasingly personalised, accessible, and culturally appropriate service responses;
- increasing the diversity of the NHS workforce, and ensuring all staff are trained and supported to understand and appropriately meet diverse needs;
- increasingly integrated care pathways, focussing on mental health challenges as well as physical illness or impairment, and better coordinated with other services including social care.

7. In addition, the Mayor has stressed the following points in response to Healthcare in London which are also of broader relevance to the NHS's contribution to reducing health inequalities:

- support for the intention to shift much provision from hospital to community settings, with the proviso community services are accessible, high quality, and incorporate a comprehensive range of primary care services, including mental health interventions and health promotion advice and support;
- the need for sustained efforts to tackle the "inverse care law" and shift the balance of NHS resources towards the most deprived areas and communities;
- the importance of using effective, inclusive community engagement processes, including equalities impact assessments, to identify in detail the potential impacts of service changes on all the different groups that make up the affected population;
- the need to further develop NHS commissioning capacity and to increase pan-London or cross-PCT commissioning to improve services for the most disadvantaged groups (eg homeless people) and those living with complex needs.

8. A wide range of the stakeholder and community groups involved in preparation of the Mayor's Health Inequalities Strategy confirm these as key issues to ensure the NHS maximises its contribution. In addition, several representatives of excluded groups report experience of a range of physical and/or attitudinal barriers to accessing health services. The Mayor urges the NHS to increase its focus on dismantling these barriers through appropriate performance management, staff training, and improved provision of language support and advocacy as well as ongoing investment in improving the physical accessibility of their services.

9. The Mayor believes action in all of these areas must be supported by well resourced arrangements for public and patient involvement. He is concerned at the loss of good-will and expertise resulting from the changes to relevant structures over recent years, and considers it essential for the NHS to invest in rebuilding community confidence and involvement in this critical aspect of providing public services. Actively considering the experience of communities, particularly those traditionally excluded from services, is a vital aspect of planning, delivering, evaluating and improving services.

THE NHS'S ROLE AS AN EMPLOYER AND CORPORATE CITIZEN

10. Traditionally the primary role of the NHS has been to respond to illness or impairment and to promote health. The Mayor welcomes the increasing emphasis on also recognising the importance of the sector's role in reducing health inequalities and influencing the wider social and economic determinants of health.

11. As a key employer, the NHS can make a major contribution to reducing health inequalities through action on income and employment. As well as having a significant influence on the health and well-being of its approximately 206 000 London employees, its influence reaches beyond its directly employed staff to thousands more working for its contractors and suppliers. The Mayor believes the NHS can and should work with him to further develop policies and deliver initiatives to:

- reduce income inequalities by supporting initiatives to increase income for those in lower income brackets, such as implementation of the London Living Wage;
- reduce worklessness by promoting access to employment, focussing particularly on the needs of those currently excluded from the labour market;
- support parents and carers in the workforce by, for example, increasing the availability of flexible working, including quality part-time work, and affordable childcare;
- increase the diversity of the workforce, ensuring a wide range of minority groups are able to access NHS-related employment opportunities including those most excluded such as refugees;
- promote the benefits of “good” work through, for example, effective implementation of workplace well-being and anti-discrimination policies;
- support other employers to invest in health and well-being at work, including initiatives to promote mental health;
- improve the retention and in-work support for disabled people and those with mental or physical health problems;
- facilitate early and positive return to work programmes for people excluded as a result of illness or impairment—both within and beyond the health service;
- support ongoing investment in skills, training, and progression initiatives for all staff, including non-clinical staff members.

12. As the procurer of goods and services, and as the manager of a large estate and related facilities, the NHS also has an important role in delivering action on several other social and environmental determinants of health. Although identified with reference to London, action on the priority areas below is also likely to be an important aspect of the sector's broader contribution to reducing health inequalities in other regions through:

- appropriate planning, location, design and construction of new facilities and the good management and use of existing facilities;
- action on climate change and other environmental and sustainability issues, including “green travel planning” for their staff and patients;
- identification and sharing of good practice on a wide range of issues related to health, well-being, and the reduction of health inequalities through action on wider determinants.

CONCLUSION

13. The Mayor welcomes the Health Committee's Inquiry into this important issue. Promoting physical and mental well-being and reducing health inequalities are key priorities for London. While significant programmes of activity have already been put in place to promote health, there is an ongoing need for more sophisticated consideration of the specific impact on groups disadvantaged by health inequalities. The Mayor remains committed to influence and support this, both through ongoing engagement with NHS London on their *Framework for Healthcare*, and through development and delivery of his Health Inequalities Strategy.

14. For more information on health inequalities in London, the Mayor would encourage the Committee to consider the range of reports published as part of the preparation of his Health Inequalities Strategy which are available at: www.london.gov.uk/mayor/health/strategy/reducing.jsp

Memorandum by the Royal College of General Practitioners (HI 96)

THE CONTRIBUTIONS OF THE NHS TO REDUCING HEALTH INEQUALITIES

1. The College welcomes the opportunity to contribute to the Parliamentary Health Care Committee's inquiry into the contributions of the NHS to reducing health inequalities.

2. The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. It aims to encourage and maintain the highest standards of general medical practice and to act as the "voice" of GPs on issues concerned with education, training, research, and clinical standards. Founded in 1952, the RCGP has over 33,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline.

3. The RCGP has its own Health Inequalities Standing Group (HISG). The group has contributed to college comment on a number of government White Papers, as well as providing evidence to the Acheson Inquiry into Inequalities in Health. Please find attached as an appendix "*Health Inequalities, the NHS and Primary Care*", a paper written by one of its members, Dr Gilles de Wildt. The HISG was involved in the production of an RCGP policy statement on matters relating to health inequalities "*Hard Lives: Improving the Health of People with Multiple Problems*", published in 2003. Material from this document is drawn on throughout our response, and a copy is enclosed.

EXECUTIVE SUMMARY

4. The College strongly believes in the aim of reducing health inequalities and delivering better patient care. The NHS next stage review could present an opportunity for this to be done if it is carried out following a full and meaningful consultation, to appropriately improve the structure and delivery of healthcare services in Britain today. We must work in partnership, in particular to improve access to diagnostics, access to urgent care and other services within the community and respond to the challenges of a geographically and culturally diverse and mobile population. Improving the quality of the patient experience and provision of care are key priorities. The RCGP is making a detailed response to Lord Darzi's invitation to submit policy ideas to the Next Stage Review.

5. As you will know "The Future Direction of General Practice—A Roadmap"⁷²⁵ (The Roadmap), has recently been issued by the RCGP. This document has the full support of the BMA, COGPEd, NAPS, NASGP, NHS Alliance, SACP and SPA as well as the College's own Patient Partnership Group. We see this Roadmap as an effective framework within which healthcare reform in primary care can take place and health inequities can be tackled. It focuses on three key areas:

- Improving the quality of the doctor patient relationship
- Developing general practices as learning organisations
- Encouraging practices to form federated entities

6. The Roadmap outlines a new model of health and social care that builds on the needs of patients and the strengths and values of general practice. The College anticipates that the good and innovative practice outlined in the document will be systematised in a flexible and appropriate way and rolled out on a wider scale to deliver patient care and reduce health inequalities across the country.

7. The RCGP strongly believes that the federated model is the best vision for reform of healthcare, this is outlined in the Roadmap and the enclosed response to the NHS Next Stage Review "Invitation to Submit Policy Ideas". This model involves different practices working together in "federations" or collaborations to deliver a wider range of quality healthcare services where patients want—closer to home—by healthcare professionals they know and trust.

8. The NHS has a significant role to play in reducing health inequalities. However the task of reducing health inequalities requires the adoption of a robust multi-agency approach to the problem, involving health and social care, housing and educational organisations.

9. Greater interaction and collaborative working between primary and secondary care is necessary to reduce health inequalities. This is outlined in a Joint Statement from the RCGP and the Royal College of Physicians⁷²⁶. Doctors must be encouraged enabled to work together across traditional boundaries to meet the needs of patients.

10. Integrated working between primary and social care is important to ensure a joined-up and holistic approach is taken to the delivery of care in the community and the effective reduction of health inequalities. This is particularly important in areas such as substance misuse, care of the elderly and mental health services where a high proportion of patients will have co-morbidities requiring non-medical interventions that could be facilitated through the development of an integrated care plan.

⁷²⁵ http://www.rcgp.org.uk/PDF/Roadmap_embargoed%2011am%2013%20Sept.pdf

⁷²⁶ "Making the best use of doctors' skills—a balanced partnership—a Joint Statement from the Royal College of General Practitioners and the Royal College of Physicians on how specialists and generalists can work together for the benefit of patients in the NHS", April 2006 <http://www.rcplondon.ac.uk/news/statements/jointRCGPG.pdf>

11. A key value of general practice is a holistic approach to disease management. This is the approach that is most appropriate to its community setting. This is particularly important in tackling health inequalities. Co-morbidity occurs disproportionately within populations that are socio-economically disadvantaged or elderly and particularly within the population which are both^{727, 728}. Therefore we believe a holistic approach to medicine in the community that accounts for co-morbidity and for other socio-economic factors is the best one to address patients and particularly to reduce health inequalities. Further, older people, those with significant co-morbidity, and those who are disadvantaged, either socio-economically or by ethnic-group, are often under-represented from clinical research trials.

12. We would therefore exercise caution with too strong a reliance on the development of clinical guidelines in primary care that are based on single disease studies using clinical research trials such as Randomised Controlled trials and other techniques. Such approaches are familiar to specialists and often appropriate for the improvement of guidelines management of single disease management in hospital settings but not always for primary care, given the exclusion of patients of certain ages and with co-morbidities. Additionally, for patients with multiple problems, several guidelines may be applicable and it is not always beneficial for patients to be treated according to the requirements of each of the guidelines, as such management could result in polypharmacy and excessive interventions.

The distribution and quality of GP services and their influence on health inequalities, including how the Quality and Outcomes Framework and Practice-based Commissioning might be used to improve the quality and distribution of GP services to reduce health inequalities

13. The development of collaborative practice between those who serve whole populations and those who serve a personal list should be prioritised. There is a risk that services will become fragmented with inappropriate healthcare reforms that shift services without account of local circumstances—partnership working between professions and services must be preserved in order to successfully tackle health inequalities. Resource allocation formulae must take account of the demands that co-morbidity places on the healthcare system and that this affects deprived areas disproportionately.

14. Targets for the management of single disease states need to be weighted to reflect the compounding effects of co-morbidity. Without this, practices that serve people with multiple problems will be systematically disadvantaged as is outlined elsewhere in this response.

Practice Based Commissioning

15. The RCGP would support practice based commissioning as a means by which GPs can work in collaboration to deliver patient-centred primary care for deprived communities. We would, however, warn against the possibility of short contract cycles (as a result of increased contestability for services) damaging the doctor-patient relationship. The involvement of the private sector could also, in theory, lead to a situation where the most “high risk” patients are marginalised in favour of “low risk” healthier patients for the purpose of profit. Appropriate systems and incentives must be developed to ensure this does not happen. The most disadvantaged in society fall disproportionately into the first category.

16. We support the use of creative use of PBC, for example to provide resources to enable practices to provide enhanced services within schools, appropriately co-located services and better delivery of mental health and substance misuse services.

Quality and Outcomes Framework

17. We recognise that the Quality and Outcomes Framework has increased the accountability and transparency of primary care. We do, however, believe that there are a number of problems associated with a framework which measures GP performance against a limited number of easily measurable clinical activities. These are:

- The indicators used in the QOF measurements do not take account of many of the illnesses which prevalent in areas of high deprivation eg alcohol and illicit drug dependence.
- The system encourages unitary care pathways ie the GPs success in identifying and treating a single disease. The system does not take co-morbidity into account, which is most prevalent in deprived areas.
- Many of the QOF trials focus on younger people and so give a distorted picture of the efficacy of treatment.

⁷²⁷ Watt G. The inverse law today. *Lancet* 2002; 360: 252–254.

⁷²⁸ Menotti A, Mulder Nissinen A, et al. Prevalence of morbidity and multi-morbidity in elderly male populations and their impact on 10-year all cause mortality: The FINE study (Finland, Italy, Netherlands, Elderly). *J Clin Epidemiol* 2001; 54: 680–686.

- It can be argued that a system which aims to standardise treatment is inherently reductionist and ignores the complexity and variation of disease between individuals. If taken to its logical extreme this can lead to a blanket, mechanistic approaches to healthcare.⁷²⁹
- The system is based on inducements, and so if a GP has to work harder in a deprived area to reach the same targets, they may be inclined to practise elsewhere leading to skills shortages in the most deprived areas.

18. We would advise that policy makers work on the basis that poverty is multi-dimensional. This should encourage greater multi-agency working and a review of the indicators used in the QOF measurements.

The effectiveness of public health services at reducing inequalities by targeting key causes such as smoking and obesity, including whether some public health interventions may lead to increases in health inequalities; and which interventions are most cost-effective

19. Whilst the RCGP does recognise the potential of interventions designed to improve modifiable determinants of health we feel that the success of these interventions depends on a change in attitudes amongst health care professionals and a more rigorous training to deliver them. Furthermore, the specific targeting of key causes of health inequalities should be done in an appropriate way that preserves the principles of a holistic approach in primary care to ensure that other services are not compromised.

Smoking

20. The most disadvantaged sectors of society have benefitted the least from the downward trend in smoking prevalence that has occurred over recent decades in the UK. There are currently about 10 million smokers in the UK, and international experience indicates that it is unlikely that this figure can even be halved within the next 10–20 years. Smoking cessation is clearly an area where the NHS has a remit and it should be involved in the following:

- Systematic identification of smokers in all health consultations
- Individual promotion of smoking cessation to all smokers
- Provision of the most intensive cessation support with which smokers are likely to comply, to all who express a desire to attempt to quit (the more intensive the support used, the more likely the smoker is to succeed)
- Routine follow up and repeat intervention where appropriate

The following areas, however, are not within the remit of the NHS, and the government should take a lead on these:

- Price—increasing the price of tobacco products decreases consumption, provided that alternative (ie smuggled or other illicit) sources of tobacco products are also closed off
- Mass media health promotion—high impact and varied advertising campaigns and other promotional activities that encourage smokers to quit, and young people to avoid starting
- Smoke-free policies—preventing smoking in public and in the workplace has a substantial impact on smoking prevalence.
- Banning all advertising and promotion of tobacco products

21. Whilst the proportion of smokers accessing cessation services and using cessation therapies has increased progressively in recent years, these proportions are still very small. We would like to see all healthcare professionals embrace smoking cessation to the extent it deserves. Doctors, nurses and other health professionals are still not trained to deliver smoking cessation interventions, and some do not see it as their job to do so.

The success of NHS organisations at co-ordinating activities with other organisations, for example local authorities, education and housing providers, to tackle inequalities; and what incentives can be provided to ensure these organisations improve care

22. The RCGP believes that PCTs should encourage and support multi-agency participation in planning and service delivery, including schools and local authorities. We would also recommend that public health specialists who have a dual role of practicing in primary care, or general practitioners with a special interest in public health have a critical part to play in such co-ordination as they possess an overview of both clinical care and organisational structure. For innovative projects to be successful we require all parts of the system (ie the care pathway) to be involved at every stage in the planning. Such projects could be supported by whole system research, and participatory and action approaches to research. We believe the NHS has a duty

⁷²⁹ Iona Heath, Julia Hippisley-Cox, Liam Smeeth. Measuring performance and missing the point?. BMJ (British Medical Journal), Volume 335, Number 7629 (November 2007), pp. 1075–1076.

to ensure that all health and social care pathways for mental health, addiction and physical health needs allow for these needs to be addressed in ways that are culturally sensitive by services that are fully integrated into the patient's community setting.

23. Resource incentives could be provided for the co-location of different agencies such as mental health, children and elderly services, where this appropriate. Incentives could also for the provision of enhanced public health services such smoking cessation, dietetic and podiatry within practices. This should also include cost of premises. The provision should be implemented in a way that will help combat health inequalities and deliver better services the most socio-economically and health disadvantaged areas.

The effectiveness of the Department of Health in co-ordinating policy with other government department, in order to meet its PSA targets for reducing inequalities

24. Cross governmental working and communication is essential. DH must work better particularly with the DfES and the Home Office and other relevant Departments to ensure the effective addressing of health inequalities and its multi-dimensional causes. The improved delivery of programmes for disadvantaged children, reducing the harms of smoking and tackling substance misuse all require a joined-up Governmental approach.

OTHER POINTS AND RECOMMENDATIONS

Interpreting Services

25. Effective interpreting services are important for appropriately delivering healthcare in some communities, often those that suffer from health disadvantaged. There are currently half a million individuals amongst four established communities (Indian, Pakistani, Bangladeshi and Chinese) whose functional English is poor. This does not include refugees, asylum seekers and recent migrants from Eastern Europe.

Defining Poverty

26. We should adopt a wider definition of poverty to include access to psychological and relational support. To overcome the problem of intense groupings of social exclusion and associated ill health, we would advocate a multi-disciplinary family case management model whereby family doctors, in collaboration with public health nurses and community outreach/development workers, focus on areas such as shopping, cooking and motivational interviewing with the aim of emphasising choice and empowerment.

Research to manage co-morbidity

27. There is an urgent need to know much more about the optimal management of co-morbidity. The evidence base of clinical practice is derived almost entirely from research into single disease states. Older people, those with significant co-morbidity, and those who are disadvantaged, either socio-economically or by ethnic group, are usually under-represented and often excluded from clinical research trials.

Continuity of Care and Personal Care

28. High quality care of multiple and compounding health problems depends on the ability of the clinician to deliver personal and continuing care over time. Such care also needs longer consultations. Where patients from disadvantaged ethnic groups also require interpretation and advocacy, consultation times need to be at least doubled.

29. I acknowledge the contributions of Dr Paramjit Gill, Dr Nat Wright, Dr Arti Maini, Dr Dave Tomson, Dr Richard Byng, Dr Angela Jones, Dr Tim Coleman and Dr Gilles de Wildt towards the above comments. While contributing to this response, it cannot be assumed that those named all necessarily agree with all of the above comments.

Dr Maureen Baker
Honorary Secretary of Council

January 2008

Memorandum by Allen Carr's Easyway To Stop Smoking (HI 97)

HEALTH INEQUALITIES

1. EXECUTIVE SUMMARY

1.1 Smoking is a major factor in health inequalities and the main cause of preventable morbidity and premature death in the UK. By tackling smoking levels, through the promotion of effective smoking cessation techniques and treatments, the NHS can make a significant impact on health inequalities in the UK.

1.2 The NHS Stop Smoking Service, however, has been found to be both ineffective and cost-inefficient. Although reliable figures are difficult to obtain, the NHS service appears to have a failure rate of around 90% at 12 months, with the cost per smoker who successfully quits being over £2,000.

1.3 Allen Carr's Easyway To Stop Smoking is the world's most successful smoking cessation method. It has been conservatively estimated that Allen Carr's Easyway clinics and books have helped over 10 million smokers quit. Independent studies conducted by highly respected scientists and published in peer review journals have shown that the clinics have a success rate of over 51% at 12 months. The fee is £220, with a full money back guarantee if the smoker fails to stop for at least 3 months. The clinics have a truly national coverage throughout the UK and offer the consistent quality of service one would expect from a highly successful global company.

1.4 Regrettably, the Government and NICE have consistently failed to recommend, and now propose specifically to exclude, Allen Carr's Easyway for use by the NHS. This has meant that smokers from the most disadvantaged sectors of society have not been able to benefit from the method on the NHS, and illustrates how the Government has failed to deliver on its commitment to expand the choice of help available in the *Choosing Health* White Paper. This British-based organisation, a global brand leader in the field of smoking cessation, is in a position to offer a more effective and cost-efficient alternative to the failing and predominantly pharmacological interventions currently provided by the NHS Service.

2. INTRODUCTION

2.1 The Department of Health has recognised that smoking is the principal avoidable cause of premature deaths in the UK. Smoking is responsible for an estimated 106,000 deaths in the UK each year, and for a wide range of diseases and conditions including cancers, coronary heart disease, impotence and infertility.

2.2 It is also widely recognised that smoking is the primary reason for the gap in the life expectancy of the rich and the poor, and is responsible for over half the excess risk of premature death between the social classes. An international study published in 2006, found that there was a two-fold difference between the highest and the lowest social strata in overall risks of dying among men aged 35–69 years (England and Wales: 21% vs 43%). More than half of this difference in mortality between the top and bottom social strata involved differences in risks of being killed at age 35–69 years by smoking (England and Wales: 4% vs 19%).⁷³⁰

2.3 One in four British adults smoke, of which half tried to quit in 2006. Of those, only 2.5% will end up quitting permanently, and only 0.2% because of the NHS Stop Smoking Service. It is therefore vital that the Government provides more effective support and greater choice for those wanting to stop smoking.

3. NHS STOP SMOKING SERVICE

3.1 The Government's favoured method of smoking cessation is intensive counselling, coupled with nicotine replacement therapy (NRT). The Government's own figures claim that the NHS Stop Smoking Service has a success rate of 51% at only 4 weeks, based on self-report.⁷³¹ According to NICE, only 13–23% of these are still abstinent at 52 weeks.⁷³² Therefore, according to the Government and NICE, the success rate of all those that use the NHS Stop Smoking Services is 7–12% at one year.

3.2 Additionally, a recent study has found that the NHS Stop Smoking Service's behavioural support has no effect and that the absolute quit rates achieved are those expected from nicotine replacement alone. The study found that the quit rate at a year is 7.7% for the NHS's basic treatment and 6.6% for the intensive treatment.⁷³³ Yet the Department of Health still proclaims the NHS Stop Smoking Service to be "world leading".

⁷³⁰ Jha P, Peto R, Zatonski W, Boreham J, Jarvis MJ, Lopez AD, Social inequalities in male mortality, and in male mortality from smoking: indirect estimation from national death rates in England and Wales, Poland, and North America, *The Lancet*—Vol. 368, Issue 9533, 29 July 2006, Pages 367–370.

⁷³¹ Statistics on NHS Stop Smoking Services in England, April to December 2006.

⁷³² NICE draft guidance on smoking cessation services, May 2007.

⁷³³ Aveyard P, Brown K, Saunders C, Alexander A, Johnstone E, Munafò M, et al. A randomised controlled trial of weekly versus basic smoking cessation support in primary care, *Thorax* (2007).

3.3 Although reliable figures are difficult to obtain, our calculations, based on Government statistics, suggest that the NHS Stop Smoking Service, including NRT products, costs between £1,996 and £3,532 for every smoker who quits for 12 months.

3.4 In addition to this, many of the NHS Stop Smoking Service's so-called "successes" remain addicted to nicotine via the nicotine products they receive from the NHS and many smokers continue to smoke and use NRT as well, in situations when they are unable to light up. The consequences are multiple dependencies and the prolonging of nicotine addiction, which leads to a decrease in the extensibility of the arteries, diseases of the circulatory system, the kidneys and the retina, as well as stomach and duodenal complaints.⁷³⁴ It should be noted that insurance companies do not consider policy holders as non-smokers while they continue to take nicotine in any way.

3.5 Consequently, the pharmaceutical companies are now competing with the tobacco companies for the nicotine addicted market and the tax payer is paying millions of pounds for the provision of nicotine to addicts, which simply perpetuates their addiction. You cannot cure nicotine addiction by giving addicts nicotine. Additionally, the *Health Services Journal* reports that "stories abound of unscrupulous advisers making up figures and of service users selling their free NHS patches."⁷³⁵ This may explain why vast quantities of nicotine patches and gum are to be found on sale on eBay.

3.6 In addition to NRT, in July 2007, NICE issued guidance recommending varenicline (Chantix/Chantix) as an effective treatment for helping smokers to quit. In November 2007, the US Food and Drug Administration (FDA) released an early communication on the ongoing safety review of varenicline, in which they stated that they had received reports of suicidal thoughts and aggressive and erratic behaviour in patients who have taken Chantix, and called on healthcare professionals to monitor patients taking Chantix for behaviour and mood changes.⁷³⁶

3.7 With smoking at the top of the agenda, and with many smokers looking to quit, we believe that the NHS should stop throwing good money after bad and stand by their commitment, in the *Choosing Health* White Paper, to expand the choice of help available and provide more support through alternative routes to meet smokers' needs.⁷³⁷

4. ALLEN CARR'S EASYWAY TO STOP SMOKING

4.1 Allen Carr's Easyway To Stop Smoking is the most successful smoking cessation method in the UK and around the world, and has been operating for over 20 years. Throughout that time, Allen Carr's Easyway clinics, conducted in groups or on a "one to one" basis, have been offering a genuine money-back guarantee, whereby smokers who do not quit for at least three months, after attending 3 sessions, are entitled to a full refund of their fee.

4.2 This money back guarantee has been offered to private and corporate clients for over 20 years and is currently offered in more than 38 countries and 100 cities. Less than 10% of clients worldwide find it necessary to claim under the guarantee.

4.3 In addition, independent studies conducted by highly respected scientists and published in peer review journals have shown that after 12 months, the success rate is still over 51%.^{738, 739}

4.4 Allen Carr's Easyway To Stop Smoking Clinics are currently PruHealth's exclusive smoking cessation service provider in the UK.

4.5 Despite the weight of both scientific and anecdotal evidence, NICE has repeatedly failed to recognise Allen Carr's Easyway To Stop Smoking Clinics, books and other products for use in the NHS. We find it extraordinary that the Government and the NHS have failed to recognise the success of Allen Carr's Easyway and the millions of people it has helped to stop smoking.

4.6 Furthermore, the draft guidance on smoking cessation that is currently being developed by NICE, with the final guidance due at the end of February, has specifically not recommended Allen Carr's Easyway for use by the NHS. In contradiction, the draft guidance recommends that group therapies can be recommended.⁷⁴⁰ In practice, this means that an established, popular, and phenomenally successful group behaviour therapy is barred, whilst leaving the door open for any new group behavioural therapy to set up and qualify for recommendation for use by the NHS, merely as a result of being a group therapy that is not Allen Carr's Easyway.

⁷³⁴ Ginzler KH, Maritz GS, Marks DF, Neuberger M, Pauly JR, Polito JR, Schulte-Hermann R, Slotkin TA 2007. *Journal of Health Psychology* 12, 2, 215–224.

⁷³⁵ Carlisle D. Will next month's ban fire up PCT stop-smoking services?, *Health Service Journal*, 14 June 2007.

⁷³⁶ FDA, Early Communication About an Ongoing Safety Review Varenicline (marketed as Chantix), 20 November 2007.

⁷³⁷ Department of Health, *Choosing Health: Making healthy choices easier*, November 2004, p.136.

⁷³⁸ Moshammer H, Neuberger M, Long term success of short smoking cessation seminars supported by occupational health care, *Addictive Behaviors* (2006), doi:10.1016/j.addbeh.2006.10.002.

⁷³⁹ Hutter H.P, Moshammer H, Neuberger M, Smoking cessation at the workplace: 1 year success of short seminars, *Int Arch Occup Environ Health* (2006) 79: 42–48, DOI 10.1007/s00420-005-0034-y.

⁷⁴⁰ NICE Public health programme draft guidance—Smoking cessation services, including the use of pharmacotherapies, in primary care, pharmacies, local authorities and workplaces, May 2007.

4.7 NICE cites that there is insufficient data available on Allen Carr's Easyway Programme to draw any conclusions. However, the two independent papers represent significant studies into the effectiveness of Allen Carr's Easyway technique and, along with the other supporting evidence that we have presented, including testimonials from thousands of former smokers who have successfully used the method and letters of support from eminent supporters of the method, the commercial success of the method over 20+ years in 38+ countries are more than sufficient for NICE to draw conclusions about the effectiveness of the smoking cessation method. NICE currently requires Allen Carr's Easyway to provide far more onerous and comprehensive scientific evidence of its effectiveness than that which NICE applies to the current NHS Stop Smoking Service.

4.8 It should also be noted that there is no reason why Allen Carr's Easyway method should be subjected to the same analysis as pharmaceutical interventions. It is not a drug, there are no side effects, it is harmless, and the service is extremely economical compared to other interventions not just with regard to the basic cost but also in terms of the money back guarantee which would be available to NHS clients in the same way as it is currently available to private clients.

5. CONCLUSION

5.1 The cutting of smoking prevalence can help to achieve a significant reduction in the levels of health inequality in the UK. Around 75% of smokers state that they would like to quit and, therefore, the NHS has the potential to make significant impact in this area.

5.2 However, the NHS is currently wasting hundreds of millions of pounds of tax payer's money by failing to recognise Allen Carr's Easyway whilst continuing to fund smoking cessation techniques which are considerably less successful and less cost-effective.

5.3 Making Allen Carr's Easyway To Stop Smoking Clinics, books, and DVDs available to smokers contacting the NHS Stop Smoking Service would provide smokers who have already been through the existing NHS Service unsuccessfully with a different, successful and hugely popular approach, and also be welcomed by the many smokers who prefer a drug-free method of quitting smoking which frees them from their addiction rather than perpetuates it.

5.4 Allen Carr's Easyway To Stop Smoking enjoys an excellent media profile, established over many years, and would prove to be a popular and highly effective addition to the NHS Service which could only benefit by association with the brand.

January 2008

Memorandum by Breakthrough Breast Cancer (HI 98)

HEALTH INEQUALITIES

EXECUTIVE SUMMARY

1. Breakthrough Breast Cancer acknowledges the importance of the Government's cross-departmental working in reducing health inequalities but believes that the role of the NHS as a healthcare commissioner and provider means it still has a vital and unique role to play.

2. Breakthrough welcomes the increase in provision of GP services announced in the Comprehensive Spending Review in October 2007 but believes it is also important that healthcare provision is tailored to the needs of the local community in order to maximise impact.

3. Information for patients will be vital in tackling inequalities, in particular in relation to choice as without improved information there is a risk this policy could widen, rather than reduce, inequalities.

4. GPs have an important role to play in reducing inequalities, particularly through the monitoring of patients encouraged by the Quality and Outcomes Framework (QOF). However, the QOF could be widened to include an indicator asking GPs to offer women over 70 a screening appointment.⁷⁴¹

5. Practice-based commissioners should be incentivised to evaluate innovative schemes they have developed for engaging hard-to-reach groups and the learning from successful schemes shared.

6. The recommendations of the Cancer Reform Strategy regarding NHS cancer screening programmes should be implemented in line with published timescales, and the Department of Health should support Primary Care Trusts (PCTs) in developing an action plan to achieve this.

7. The Health Inequalities Intervention Tool, launched in August 2007, offers an evidence-based approach that should facilitate the development of local solutions to the issue of inequalities.

⁷⁴¹ While Breakthrough warmly welcomes the commitment in the Cancer Reform Strategy to extend the age range for screening invitations to 47–73 by 2012, it is important that women aged over 73 are still able to access screening by making their own appointment after this date.

8. It will be important for the Government to evaluate the Health Inequalities Intervention tool as soon as possible and to consider commissioning further research into additional interventions to develop the tool further if it proves successful.

1. INTRODUCTION

1.1 Breakthrough Breast Cancer is the UK's leading breast cancer charity and is committed to fighting breast cancer through research, campaigning and education. Breakthrough has established the UK's first dedicated breast cancer research centre, in order to realise our vision: a future free from the fear of breast cancer. Breakthrough campaigns for policies that support breast cancer research and improved services, as well as promoting breast cancer education and awareness amongst the general public, policy makers, health professionals and the media.

1.2 Breakthrough works closely with healthcare professionals, patient advocates, and researchers. Our memorandum incorporates the views of Breakthrough and members of its Campaigns & Advocacy Network (Breakthrough CAN)—which is made up of over 1000 individuals and organisations. Many members of Breakthrough CAN have personal experience of breast cancer as well as being involved in and working alongside their local NHS to try to deliver better treatments and services for people affected by breast cancer and their families.

1.3 Breakthrough welcomes this inquiry into health inequalities. Our memorandum focuses on the ways in which the NHS can help to reduce health inequalities, in particular the role of public health services and information. Breakthrough staff and CAN members would be willing to provide oral evidence to this inquiry, if the committee would find this useful.

2. THE EXTENT TO WHICH THE NHS CAN REDUCE HEALTH INEQUALITIES

2.1 Breakthrough acknowledges that the reduction of health inequalities will involve the work of a number of Government departments to tackle the range of issues surrounding inequality, such as housing, education, taxation and employment.

2.2 However, as both a purchaser and provider of healthcare services, the NHS is uniquely placed to contribute to the reduction of health inequalities. Ensuring that healthcare provision across the country allows every community access to services that are both sufficient in capacity and appropriately targeted to meet local needs is an essential step in reducing inequalities. To that end, Breakthrough welcomes the decision in the recent Comprehensive Spending Review to provide the funding for 100 new GP practices in the 25% of PCTs that have the lowest provision of GPs per head,⁷⁴² as recommended by the interim report of the NHS Next Stage Review.⁷⁴³ This additional provision of GP services is potentially important in reducing health inequalities as statistics show a broad correlation between areas with the lowest GP provision and the lowest life expectancy.⁷⁴⁴ GPs are the “gatekeepers” for referral to secondary care and having more limited access to their services is therefore likely to affect the early presentation and diagnosis of serious conditions such as breast cancer, which in turn could increase mortality rates in these communities. The role of GP services in reducing health inequalities is discussed further in section 3 below.

2.3 In addition to providing more GP services, it is important that healthcare services in general are tailored to the specific needs of the communities they operate in. There is now a large body of evidence to suggest that incidence and mortality rates for different diseases vary among different ethnic and socioeconomic groups. For example, although breast cancer incidence is greater among women in the most affluent socioeconomic groups, these women have a significantly higher survival rate for breast cancer than women in the least affluent groups.⁷⁴⁵ Utilising existing knowledge about variations in incidence and mortality alongside information on the population within each PCT will aid the provision of services tailored to the community and thus can be used to help improve awareness, early detection and preventative services to achieve the biggest impact on incidence and mortality.

2.4 While the NHS can make use of the information available to it in order to help reduce inequalities through better commissioning, the information provided to patients and the public can also be beneficial in reducing inequalities. We know that the earlier that breast cancer is detected and diagnosed, the more likely it is that treatment will be successful. In order to encourage early detection, it is important that all women are breast aware (ie that they check their breasts regularly for the signs and symptoms of breast cancer and present any unusual symptoms to their GP at the earliest possible opportunity) and that women aged over 50 understand the benefits of attending their breast screening appointments when invited. Research indicates that women's awareness of all the breast cancer signs and symptoms is low, especially among older women, some BME groups and socially disadvantaged women, and that fear and lack of awareness may be

⁷⁴² HM Treasury, Meeting the aspirations of the British people: the Pre-Budget Report and Comprehensive Spending Review (October 2007) page 98.

⁷⁴³ Professor Lord Ara Darzi, *Our NHS, our future: NHS Next Stage Review Interim report* (October 2007) page 25.

⁷⁴⁴ Professor Lord Ara Darzi, *Our NHS, our future: NHS Next Stage Review Interim report* (October 2007) page 20.

⁷⁴⁵ Coleman, M.P., *et al.*, Trends and socioeconomic inequalities in cancer survival in England and Wales up to 2001. *Br J Cancer*, 2004. 90(7): p. 1367–73 and Coleman, M.P., *et al.*, Cancer Survival Trends in England & Wales, 1971–1995 Deprivation & NHS Region. 1999: The Stationery Office.

a barrier to taking up breast screening appointments. There is a necessity for support at all levels for the new National Awareness and Early Diagnosis Initiative, as recommended in the Cancer Reform Strategy. This Initiative will coordinate a programme of activity to support interventions to raise awareness of the signs and symptoms of early cancer and encourage people to seek help sooner and will lead on the development of a tool for measuring awareness levels and supporting high quality evaluations of pilot projects.

2.5 However, the information that is offered must be clear, transparent, accessible in its style and content, and should signpost to other information sources. Furthermore, it is important that the information is independent and unbiased so that it represents a source of information that patients feel they can trust and rely upon. Information can only help to reduce inequalities if it is equally accessible to all, and this may require tailoring information to the needs of different groups. In order to assist with this, the NHS may wish to consider working in partnership with charities and community groups who have existing expertise in this area.

2.6 Information will be particularly important in ensuring that the policy of patient choice does not widen inequalities. According to the most recent Patient Choice Survey, conducted by the Department of Health in May 2007, only 44% of patients reported being offered a choice of treatment location when referred by their GP and this figure represents a decline from the previous survey.⁷⁴⁶ Only 38% of patients were aware they had a choice of treatment location prior to visiting their GP.⁷⁴⁷ These figures may indicate that implementation of the choice agenda is facing some challenges and this will need to be addressed to ensure choice delivers full benefits to patients.

2.7 In particular, choices need to be communicated effectively in order that all patients may benefit—eg helping those who are less health-literate to make informed choices as well as providing detailed information to those who want it. If this cannot be achieved effectively then there is a danger that choice will be the preserve of the more educated, higher socioeconomic groups and this potential to access the best services and treatments will contribute to the widening of inequalities rather than reducing them.

3. THE ROLE OF GP SERVICES IN REDUCING INEQUALITIES

3.1 GP surgeries are very often the first, and most familiar, point of contact with the NHS for the public. This means they can play a central role in the reduction of inequalities by helping to disseminate information and generate awareness of the signs and symptoms of illnesses, and preventative measures, within their communities.

3.2 GPs themselves can support the reduction of inequalities in a number of ways. The Quality and Outcomes Framework (QOF) already attempts to help GPs identify patients who are most at risk of conditions such as cardiovascular disease and lung cancer through monitoring the prevalence of smoking, high blood pressure and other risk factors among patients. However, the role of the QOF in encouraging early detection and diagnosis of disease could potentially be expanded into new areas, such as encouraging women to attend breast screening appointments.

3.3 The NHS Breast Screening Programme is estimated to save approximately 1,400 lives each year, in England alone.⁷⁴⁸ Currently, women aged between 50 and 70 are invited for breast screening appointments every three years. However, as the risk of breast cancer continues to increase with age, it is not only important that women attend when invited but also take steps, once they reach the age of 70, to continue to participate in the breast screening programme.

3.4 Women over 70 can request their own screening appointments via their GP or local screening unit. However, a survey commissioned by Breakthrough in 2006⁷⁴⁹ revealed that nearly all women (90%) in this age group have never requested their own screening appointment and of these, over a quarter (28%) did not think they needed to. In addition, almost all women aged 70 (97%) did not realise they are most at risk of developing breast cancer because of their increasing age.

3.5 Additionally, further research conducted by Breakthrough in 2007⁷⁵⁰ found that the vast majority (88%) of those women surveyed aged 70 and over reported that since turning 70 their GP or surgery had not talked to them about continuing to make their own breast screening appointments. There is, therefore, a potential role for the QOF in encouraging GPs to make women aged over 70 aware of their right to request an appointment.

3.6 Breakthrough has actively campaigned for the extension of the screening age range to include older women, and we therefore warmly welcome the commitment in the recent Cancer Reform Strategy to extend the age range to include women aged 47 to 73 by 2012. However, after these changes are fully implemented, it will still be important for women beyond the age of 73 to request their own appointments.

⁷⁴⁶ Department of Health, Report of the National Patient Choice Survey, England (May 2007).

⁷⁴⁷ Department of Health, Report of the National Patient Choice Survey, England (May 2007).

⁷⁴⁸ Advisory Committee on Breast Cancer Screening, Screening for Breast Cancer in England: Past and Future (2006) p21.

⁷⁴⁹ 2006 British Boob Survey, Breakthrough Breast Cancer. Survey carried out between July and August 2006 by ICM Research, involving 2,200 UK women aged 50 or over who were interviewed by telephone.

⁷⁵⁰ 2007 British Boob Survey, Breakthrough Breast Cancer. ICM Research was commissioned by Breakthrough Breast Cancer to carry out a survey between July and August 2007. The survey involved 1,190 women aged 50 and over who were interviewed by telephone.

3.7 GPs working as practice-based commissioners, or as part of commissioning clusters, may also be able to develop innovative ways of working with hard-to-reach groups within their practice area. This will help ensure all local residents are able to benefit from prevention and early detection advice as well as other services offered in primary care. Breakthrough has heard anecdotally of successful schemes for increasing uptake of breast screening among hard-to-reach groups, for example Asian women who do not speak English as a first language. A scheme in West Yorkshire developed photo information packs for Mirpuri- and Syhelti-speaking women, which successfully increased screening uptake among those women. The Jarvis National Breast Screening, Training and Diagnostic Centre used a health-promoting roadshow run by a locally-known interpreter to achieve a similar effect.

3.8 Initiatives such as these, held in community locations or run by staff fluent in languages other than English appear to be of benefit in engaging hard-to-reach groups and may thus help to reduce inequalities by ensuring wider access to services. However, more research into the most effective interventions in this context is needed. The Government should consider incentivising GPs already running such services—to evaluate the impact of their work and subsequently promote effective interventions of this kind among other practice-based commissioners and clusters.

3.9 More broadly, GP surgeries can provide a wide range of health information for patients—provided by the NHS and by organisations such as specialist medical charities. However, this information should also be dispensed through a wider variety of community institutions, where appropriate, such as libraries, colleges, pharmacies and walk-in centres.

4. PUBLIC SERVICE AGREEMENT (PSA) TARGETS

4.1 The launch of the Government's Health Inequalities Intervention tool in August 2007⁷⁵¹ represents an opportunity to take an evidence-based, localised approach to the issue of reducing health inequalities, which may be of benefit in achieving positive change. The reasons for, and severity of, health inequalities will differ from area to area and PCTs are therefore well-placed to devise their own localised strategy for effectively tackling this issue. The evidence-based interventions offered by the Health Inequalities Intervention tool will help PCTs to design strategies in the most appropriate manner for the particular challenges they face, therefore offering a greater potential benefit due to the targeted nature of the interventions.

4.2 It may also be beneficial to assess the impact the tool is having, in order to assess in what way and how regularly it is being used by local authorities, as well as how successful it is in achieving a reduction in inequalities. The Government may also wish to consider devoting resources to investigating the efficacy of other potential interventions in order to widen the range of measures available to tackle this issue.

5. RECOMMENDATIONS FOR ACTION

5.1 The NHS must ensure that the entire population has equal and adequate access to GP services, including by providing more GPs if necessary to bring those PCTs with the lowest numbers up to the national average number of GPs per head.

5.2 The Department of Health must develop a strategy to improve awareness of, and access to, choice of healthcare provider as part of its development of information within the NHS.

5.3 The Department of Health should consider including, within the Quality and Outcomes Framework, an indicator asking GPs to inform women aged over 70 of their right to request a screening appointment. This could also be further supplemented by an indicator relating to the number of women aged over 70 attending screening.

5.4 The NHS should work with patient organisations and specialist medical charities in order to improve information for patients by making use of existing data and resources from these organisations. Breakthrough would be happy to provide information to the NHS should they wish to pursue this possibility further.

5.5 The Department of Health should develop a system to incentivise GPs currently operating innovative services for hard-to-reach groups to evaluate these schemes, so that learning from successful schemes can be shared with other practices.

5.6 The Department of Health should evaluate the impact of its Health Inequalities Intervention tool at the earliest appropriate opportunity, and should also consider undertaking research into additional interventions that could be utilised as part of this tool to further improve its potential to reduce inequalities.

January 2008

⁷⁵¹ Launched by Dawn Primarolo MP, 21st August 2007.

Memorandum by the West Midlands Perinatal Institute (HI 99)

HEALTH INEQUALITIES

EXECUTIVE SUMMARY

1. This submission deals with health inequalities in maternal and perinatal care. The PSA target for Infant Mortality is unlikely to be met, and we submit that this is because of a lack of an appropriate strategy. To tackle inequalities and associated problems, there is a need to take a wider view and consider the underlying factors, most of which occur before birth.

2. Such an approach requires core information from each mother and baby, based on which performance indicators for maternity services can be defined. Such information, matched with area based indicators of deprivation, will allow mapping of the areas most affected, indicate where the quality improvement efforts are most needed, and help monitor the effects of service enhancements.

3. We therefore propose:

- that standardised collection of core information with health and social indicators be established forthwith, to include all maternities in the NHS;
- that provision of such information by Trusts should be part of each PCT's commissioning contract, and should be monitored by the SHAs; and
- that this information be used to develop equitable maternal and perinatal services, with appropriate resources and staffing to reduce inequalities and deprivation.

1. INTRODUCTION

1.1 The West Midlands Perinatal Institute is an NHS organisation engaged in an active programme to reduce the high perinatal / infant mortality in our region.

1.2 To an increasing extent, our efforts are also assisting service improvements in other regions. For example, we have already trained staff from 75 NHS maternity units in the use of our RCOG-endorsed customised growth charts, which adjust for individual variation and therefore improve the detection of fetal growth restriction in multi-ethnic maternity populations. We have also developed standardised, hand held maternity records which have so far become established in over 200,000 pregnancies per annum.

1.3 A major focus in the West Midlands has been to collect information on mothers and babies in an effort to improve our understanding of the effects of deprivation. We believe that our work on health inequalities is of relevance to the NHS in general.

2. THE INEQUALITIES GAP

2.1 As acknowledged in last year's Infant Mortality PSA Target Review⁷⁵², the inequalities gap has been increasing rather than decreasing since the chosen 1997 baseline. It is unlikely that the target of a 10% reduction will be achieved by 2010 if the current path is followed, and there seems to be little in the "Implementation Plan"⁷⁵³ which would alter this expectation.

2.2 We believe however that it is still possible to make significant inroads towards achieving the target. The Perinatal Institute has been assisting the deliberations of the Health Inequalities Unit (HIU) as concerns the Infant Mortality targets. However it seems that this government initiative is locked into a confined remit and unable to consider a wider view. While an inequalities target is laudable, it is worth to pause and examine whether its current framework is helpful in addressing the main issue.

2.2.1 Firstly, the use of a social classification based on "Routine and Manual" is not the best measure of deprivation for this target, as reliance on paternal profession excludes many single mothers. Instead, we use an area based indicator such as the Index of Multiple Deprivation which can highlight deprivation rates and associated factors in geographical entities down to ward level. This approach is able to inform the necessary action, as many practices, health centres and children's centres serve geographically defined populations.

2.2.2 Secondly, The PSA target refers to Infant mortality. Most infant deaths occur in the first week of life, and many have antecedent ie intrauterine causes. There is increasing recognition of the need to look at the antenatal period to address inequalities⁷⁵⁴.

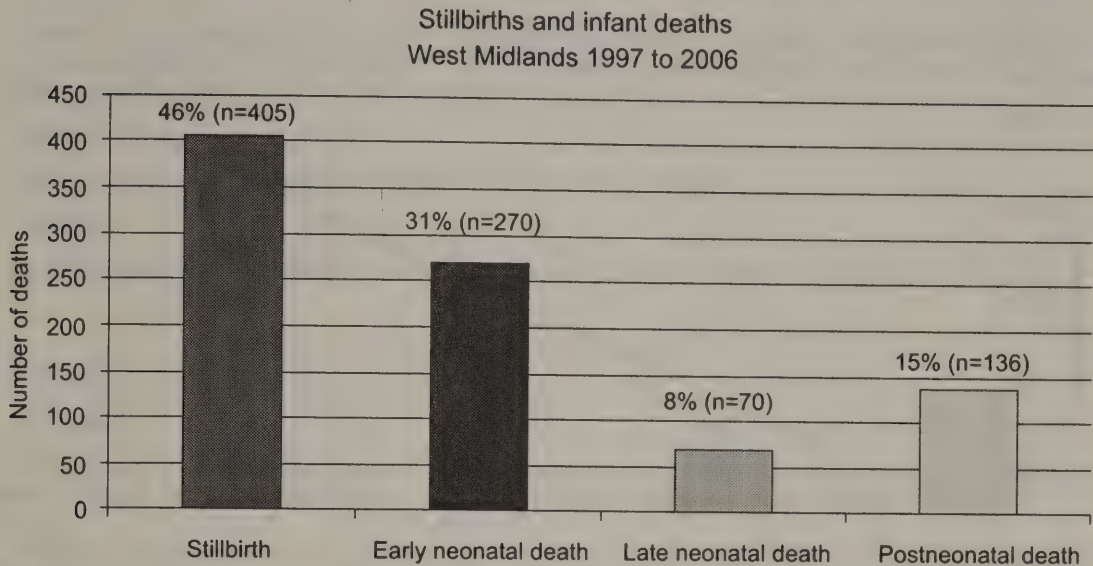
2.2.3 From the time when a baby reaches viability (24 weeks gestation) until age 1 year, stillbirth is the largest group, and together with early neonatal death, constitutes over three quarters of the mortality over this period (Figure 1). However stillbirths are not even discussed in the DoH—HIU reports^{752, 753}.

⁷⁵² Review of Health Inequalities—Infant Mortality PSA Target. Dept of Health, 2007
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_065544

⁷⁵³ Implementation plan for Reducing Health Inequalities in Infant Mortality Dept of Health, 2007
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_08.1337

⁷⁵⁴ Born Unequal: Why we need a progressive pre-birth agenda. Fabian Society, 2007- Policy Report 61
fabians.org.uk/publications/policy/bamfield-prebirth-07/

Figure 1: Relative proportions of Stillbirths (from 24 wks), Early (to age 7 days), Late (days 8 to 28) and Post Neonatal Deaths (to 12 months), West Midlands 1997–2006



2.3 However national and regional confidential enquiries have shown clearly that the majority of deaths are associated with substandard care and are potentially avoidable^{755, 756}. Excluding congenital anomalies, most stillbirths are associated with fetal growth restriction⁷⁵⁷, and failure of the fetus to grow is not only linked to a 5–10 fold increased risk of intrauterine death, but also to increased complications during labour, asphyxia, need for neonatal special care, cerebral palsy, and problems in adult life including heart disease and diabetes. However fetal growth is also not discussed in the DoH—HIU Reports^{758, 759}.

3. UNDERSTANDING UNDERLYING FACTORS

3.1 In broad terms, and excluding congenital anomalies, prematurity is the largest single factor associated with neonatal deaths, and intrauterine (fetal) growth restriction is the most common factor associated with stillbirth. Both prematurity and fetal growth restriction are more common in deprived areas, and it is therefore not surprising that there is a strong link between social deprivation and perinatal mortality (= a composite of stillbirth and early neonatal deaths).

3.2 Figure 2 demonstrates the high correlation ($R=0.92$) between perinatal mortality rate (10 year average) and deprivation score (IMD 2004) for the 17 West Midlands PCTs.

⁷⁵⁵ Confidential Enquiry into Stillbirths and Deaths in Infancy—CESDI 8th Annual Report 2001
www.cemach.org.uk/Publications/CEMACH-Publications/CESDI-Publications.aspx

⁷⁵⁶ Confidential Enquiry into Stillbirths with fetal growth restriction. Perinatal Institute 2007
www.perinatal.nhs.uk/rpnm/CE_SB_Final.pdf

⁷⁵⁷ Kady S, Gardosi J. Perinatal mortality and fetal growth restriction. *Best Pract Res Clin Obstet Gynaecol* 2004;18:397–410.

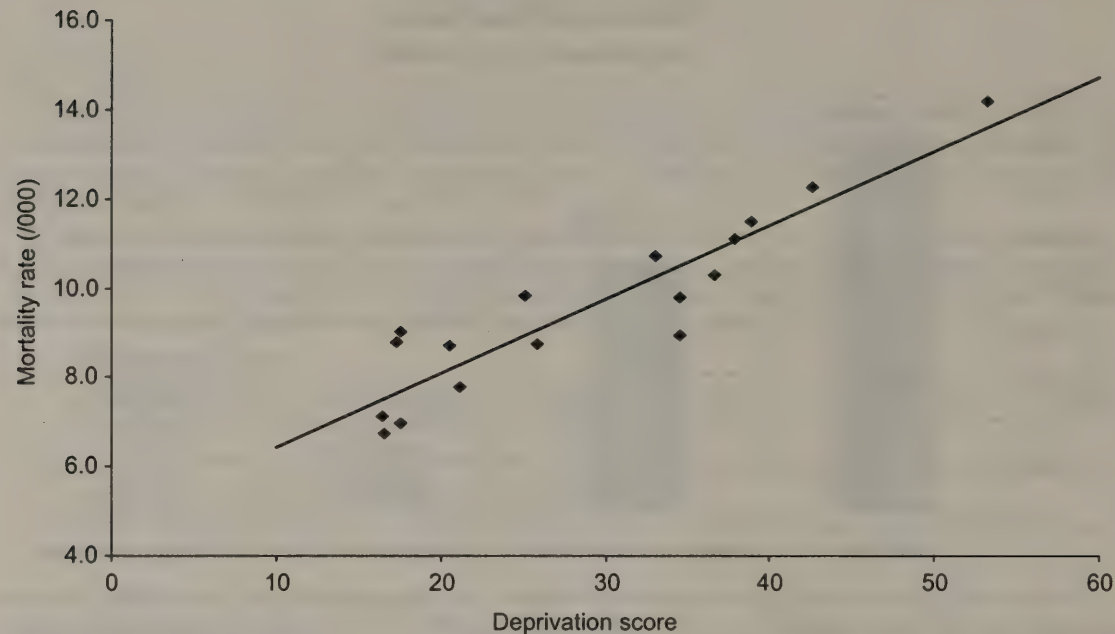
⁷⁵⁸ Review of Health Inequalities—Infant Mortality PSA Target. Dept of Health, 2007

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_065544

⁷⁵⁹ Implementation plan for Reducing Health Inequalities in Infant Mortality Dept of Health, 2007

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_08.1337

Figure 2: Perinatal Mortality and deprivation (IMD 2004), West Midlands PCTs, 1997–2006.
Correlation: $R = 0.92$



3.3 However even within PCTs there is substantial variation, with focal points of deprivation and high mortality. While perinatal deaths are useful headline figures, they are only the tip of the iceberg, and are too rare to allow meaningful assessment at local (eg ward) level.

3.4 Instead, the effect of inequalities on the service can be mapped, and interventions monitored, with the help of a standard core maternity dataset. Importantly, these are precise, individual data rather than aggregated summary estimates, which allows assessment within demographic and geographic subgroups, and cross-correlation with indices of deprivation.

3.5 Based on this data, appropriate process- or performance indicators can be defined, and these can be added to / amended as necessary to address the issues which are locally relevant.

3.6 Stakeholders in Birmingham and the Black Country have defined a core dataset; data collection is ongoing since 2007 and includes information on 10,000 pregnancies and births to date. The data provide baseline rates on maternal age, ethnicity, obesity, teenage pregnancy etc, and 5 agreed performance indicators (early booking, continuity of carer, fetal growth restriction, smoking cessation, and breastfeeding⁷⁶⁰).

4. PERFORMANCE INDICATORS FOR MATERNITY SERVICES

4.1 Early booking

Rationale:

Early visit allows the mother to receive information and choice about tests, and allows the health service to assess social and medical risk. Indicates good “access”. Recommended by Maternity Matters⁷⁶¹

Metric:

The proportion of women who attend their first appointment by 12 weeks (target: 80%)

Finding:

Mothers from the most deprived areas are significantly less likely to be booked early in pregnancy

⁷⁶⁰ Gardosi J, Beamish N, Francis A *et al*. Stillbirth and infant mortality, WM 1997–2005: Trends, Factors, Inequalities. Perinatal Institute, 2007 www.perinatal.nhs.uk/pnm/WM_SB&IMR_2007report.pdf

⁷⁶¹ Maternity Matters; Choice, access and continuity of care in a safe service. Dept of Health 2007 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073312

4.2 Continuity of carer

Rationale:

Desired by mothers, and important to establish relationship with primary care provider. Facilitates support, early recognition of medical and social problems, incl. domestic and mental health—importance of which are also highlighted in maternal mortality reports⁷⁶².

Metric:

Proportion of visits which are with the same midwife (target: 75%)

Finding:

Mothers from the most deprived areas are significantly less likely to have good continuity of carer

4.3 Fetal growth restriction

Rationale:

Fetal growth problems are associated with stillbirth, perinatal mortality, cerebral palsy, and diseases in later life. Early recognition and timely delivery is recommended by RCOG guidelines⁷⁶³

Metric:

Number / proportion of babies with birthweight indicating growth restriction (< 10th customised centile); and proportion of these which were detected by the health service antenatally (target: 60%).

Findings:

Mothers from most deprived areas are significantly more likely to have a growth restricted baby. Detection rates are low overall.

4.4 Smoking cessation

Rationale:

Apart from adverse maternal effects, smoking increases fetal growth restriction and prematurity. National target: reduce to 15% by end of pregnancy.

- Note: A smoking target ignoring ethnic variation may be falsely reassuring; our overall rate is 14.3% but this figure includes a high proportion of Asian mothers whose smoking rate is 1%, while 21.5% of European mothers continue to smoke.

Metric:

Smoking rates at booking and at the end of pregnancy

Findings:

Expectant mothers from the most deprived areas are significantly more likely to smoke during pregnancy

- Note: There is also substantial variation within subgroups—e.g. 46% of teenagers (< 18) smoke in early pregnancy, and 90% of these continue to smoke until the end of pregnancy

4.5 Breast feeding

Rationale:

Breastfeeding initiation is a national target, with the aim to increase the rate by 2% per annum.

Metric:

Proportion of mothers who have commenced breastfeeding before discharge from the delivery unit

Findings:

Mothers from the most deprived areas are significantly less likely to breastfeed

⁷⁶² Confidential Enquiry into Stillbirths and Deaths in Infancy: Saving Mothers Lives 2003–2005. www.cemach.org.uk/Publications/CEMACH-Publications/Maternal-and-Perinatal-Health.aspx

⁷⁶³ Royal College of Obstetricians and Gynaecologists. The investigation and management of the small-for-gestational age fetus. RCOG Green Top Guideline No. 31, Nov 2002. www.rcog.org.uk/index.asp?PageID=.531

5. REQUIREMENTS FOR DATA COLLECTION

5.2 In the long term, the National Programme for IT should be expected to provide this information, but progress within that initiative has been slow and disappointing, and has resulted in widespread lack of confidence.

5.3 The main requirement for obtaining this basic information is the relatively modest investment for data analysis, which can be done regionally, and a dedicated data clerk in each maternity unit. The other requirements are already tried and tested and immediately available to other NHS organisations—including

- web based, NHS owned data collection software running on NHS.net,
- training for data clerks, and
- standardised maternity records from which to capture the required information

6. IMPLICATIONS

6.1 The ability to highlight inequalities down to ward or practice level will guide the service to invest the added effort where it is needed. The “upstream” focus on health and social care factors will be able to address inequalities and tackle mortality through prevention.

6.2 Demographics and performance indicators can inform a variety of local initiatives—eg to

- signpost early pregnancy services to enhance access for all groups
- improve awareness of social circumstances and develop targeted risk strategies
- address high caseloads and endemic shortages of midwifery staff
- develop models to support most vulnerable groups—eg through outreach workers
- develop protocols and multi-agency care pathways for a more equitable service

6.3 Additional performance indicators can be agreed by local stakeholders.

6.4 Such information will also assist the establishment of priorities for commissioning. A detailed examination of these implications is outside the scope of this submission. However, there needs to be consideration on whether and how a flat tariff can address inequalities, the use of PbR and non-PbR funding, and the implications of practice based commissioning.

6.5 But regardless of how the service is funded, good intelligence about social deprivation and its effects on maternity care and perinatal and infant outcome is long overdue, and will be the cornerstone for progress in reducing the stark inequalities in this field.

Memorandum by Nick Seddon (HI 100)

HEALTH INEQUALITIES INQUIRY

1. In the NHS a strong emphasis is placed on equity. There are few official government reports or academic studies concerned with the underlying principles of the NHS that don't include some reference to equity or one of its close synonyms—fairness and social justice. This is the underlying idea of one of its founding principles: that it should be free at the point of use, available to all, irrespective of the ability to pay. Illogically, it is assumed that taxation and public service provision are somehow a proxy for equity, despite the fact that the commitment to equity is by no means unique to the NHS. Most OECD member countries have long achieved close to universal coverage of their population for a fairly comprehensive package of health services. In most of these countries, this is achieved as a result of a variety of public insurance arrangements aimed at ensuring equitable access.⁷⁶⁴

2. Whenever there is any serious consideration of alternative ways of structuring and organising healthcare in the UK, it comes up against the notion that the NHS delivers an equitable service: ours, it is assumed, is vastly superior to other countries. “To consider alternatives is to signal a willingness to depart from these ideals. In fact, to not consider alternatives is to show a lack of commitment to these ideals, while to defend the status quo is to endorse inequality.”⁷⁶⁵ As has repeatedly and conclusively been demonstrated, “there are social groups such as the poor or the ethnic communities who are significantly disadvantaged in their access to, and use of, the NHS, and that the present combination of bureaucratic allocation and professional authority actually favours the better off.”⁷⁶⁶

⁷⁶⁴ Van Doorslaer, E., Masseria, C., et al., *Income-Related Inequality in the Use of Medical Care in 21 OECD Countries*, OECD Health Working Papers No. 14, Paris: OECD, 2004, p. 8.

⁷⁶⁵ Seddon, N., *Quite Like Heaven? Options for the NHS in a Consumer Age*, London: Civitas, 2007.

⁷⁶⁶ Dixon, A., Le Grand, J., Henderson, J., Murray, R., and Poteliakhoff, E., *Is the NHS equitable? A review of the evidence*, London, LSE, 2003, p. 5. For a more strident treatment, see: Adonis, A., and Pollard, S., *Class Act: The Myth of Britain's Classless Society*, Harmondsworth: Penguin, 1998, p. 155.

HEALTH INEQUALITIES

1.1 All the evidence suggests that there are entrenched inequalities in health in the UK. It is also clear that these inequalities are widening. However, to a substantial degree they are not the result of the healthcare system. This has been the finding of a number of reports. For example, it was the finding of the Black Report, delivered by Sir Douglas Black in 1980. His report showed unmistakably that death rates for many given diseases were higher for the lower social and occupational classes than for the higher classes, and that overall the health gap between rich and poor appeared to be growing.⁷⁶⁷ “It was a shock to find that health inequality not only existed,” as one commentator puts it, “but also seemed . . . to have increased in a situation where everyone could get health care without payment at a time of illness.”⁷⁶⁸ Black and his group did not, however, blame the NHS for this state of affairs. The real problems, in so far as they could be established, seemed to lie in issues such as “income, work (or lack of it), environment, education, housing, transport and “life-styles””.⁷⁶⁹

1.2 In 1998 Sir Donald Acheson chaired a report for the Blair government entitled the *Report of the Independent Inquiry on Inequality in Health*. The Acheson report revealed that “unacceptable inequalities in health persist”, that these “inequalities affect the whole of society”,⁷⁷⁰ and that “the gap in health between those at top and bottom of the social scale has widened”.⁷⁷¹ The Acheson report, like the Black report before it, highlighted the link between social and economic disadvantage and health outcomes, and rather than blame the NHS its recommendations focussed on things like education, employment, benefits, housing, the environment, and “living standards”.⁷⁷² Combating inequalities in health is about more than improving the healthcare service.

1.3 In 2006, the DH found that health inequalities have been continuing to get worse. Not only, are lower socio-economic groups less healthy,⁷⁷³ but the relative gap is growing. Between 1997–99 and 2002–04, “the trend shows a widening in the relative gap between infant mortality in the routine and manual group and in the total population”.⁷⁷⁴ This unedifying trend continues unabated. Sir Ara Darzi’s interim report documents how the gap in life expectancy between the most deprived and least deprived areas in England is nearly 10 years for men.⁷⁷⁵ E.g. premature death rates for coronary heart disease vary from 2.1 deaths per 10,000 of the population in the London borough of Kensington and Chelsea to 8.5 per 10,000 in Hartlepool.⁷⁷⁶ The opportunity to access healthcare is actually worse in areas of greater need.⁷⁷⁷

UNEQUAL PROVISION

2.1 What is becoming patently clear is that although inequality may be the result of multiple factors for which no health system can be directly blamed or credited, the NHS often does little to combat inequality—and may even make it worse. Inequality and inequity are not the same. Inequality is a factual matter, while inequity is a moral matter. When talking about the system, the NHS, it is inequity that is unacceptable. There are numerous ways that equity and inequity in healthcare can be defined, but the principle one concerns access. An equitable service offers equality of access to health care to individuals in equal need. This is generally referred to as horizontal equity, and it contrasts with vertical equity, when individuals with different levels of need consume appropriately different amounts of healthcare.⁷⁷⁸ To put it another way, the treatment available to individuals should depend only on their need for treatment, not on factors that are irrelevant to that need. The most emotive factor irrelevant to need is, of course, socio-economic economic status.⁷⁷⁹

2.2 Complex debates revolve around the definitions of these terms. For instance, the difference between access and utilisation means that if someone chooses not to use the service for whatever reason then it’s not fair to then say that resultant inequalities in utilisation relative to need were inequitable. There are also awkward problems connected with defining need, such as whether it is in terms of health status or capacity to benefit,⁷⁸⁰ and these have been outlined in some detail in numerous studies. In general, given how hard

⁷⁶⁷ *Inequalities in Health: The Black Report and the Health Divide*, Harmondsworth: Penguin, 1988, p. 2.

⁷⁶⁸ Bartley, M., *Health Inequality: An Introduction to Theories, Concepts and Methods*, Oxford: Polity Press, 2004, p. 8.

⁷⁶⁹ *Inequalities in Health: The Black Report and the Health Divide*, p. 4.

⁷⁷⁰ Acheson, D., Barker, D., Chambers, J., Graham, H., Marmot, M., and Whitehead, M., *Report of the Independent Inquiry on Inequality in Health*, London: HMSO, 1998, p. 1.

⁷⁷¹ Acheson, D., et al., *Report of the Independent Inquiry on Inequality in Health*, 1998, p. 2.

⁷⁷² Acheson, D., et al., *Report of the Independent Inquiry on Inequality in Health*, 1998, p. 36.

⁷⁷³ Hawe, E., *Compendium of Health Statistics 2007*, 18th edn, Oxford: Office of Health Economics, 2007, p. 91.

⁷⁷⁴ *Tackling Health Inequalities: Status Report on the Programme for Action—2006 Update of Headline Indicators*, London: DH, December 2006.

⁷⁷⁵ Darzi, A., *Our NHS Our Future: NHS Next Stage Review Interim Report*, London: The Stationary Office, 2007, pp. 19–20.

⁷⁷⁶ Gainsbury, S., “Heart death rates show a nation of inequalities”, *Health Service Journal*, 17/01/08.

⁷⁷⁷ DH, Press release: “Web tool launched to improve life expectancy in disadvantaged areas”, 23/08/07.

⁷⁷⁸ Morris, S., Sutton, M., Gravelle, H., *Inequity and inequality in the use of health care in England: an empirical investigation*, CHE Technical Paper Series 27, York: University of York Centre for Health Economics, 2003, p. 28.

⁷⁷⁹ See: Dixon, A., et al., *Is the NHS equitable? A review of the evidence*, p. 6.

⁷⁸⁰ Stevens, A., Gillam, S., “Needs assessment: from theory to practice”, *BMJ*, 1998; 316 (7142): 1448–52.

it is to attribute outcomes to choices, inequality in utilisation tends to be used as a proxy for inequalities in access, and different studies pitch for different qualifications of need based on a combination of detailed information about patients and carefully justified “value judgements”.⁷⁸¹ Ultimately, a slew of studies has shown that “lower socio-economic groups use services less in relation to need than higher ones”.⁷⁸² This was acknowledged by Tony Blair in 2003 when he said the NHS does not provide equitable access to services.⁷⁸³

HORIZONTAL INEQUITY

3.1 One test of the horizontal equity of healthcare provision in the NHS is hip replacement, since it is a common, effective, low risk and long established health technology. In 2006 the York University Centre for Health Economics reported that studies of elective total hip replacement in the NHS between 1991 and 2001 have yielded striking examples of the unequal delivery of specialist health services across socio-economic groups. Survey data for people living in deprived areas suggests that they may be more likely to need hip replacements.⁷⁸⁴ By setting this against administrative data which show that people living in deprived areas are less likely to receive hip replacement,⁷⁸⁵ the York study was able to conclude that there is substantial socio-economic inequity in the use and delivery of elective total hip replacement.⁷⁸⁶ There is evidence that this is a widespread phenomenon. Also in 2006, an article in the journal *Rheumatology* found that while need for hip and knee joint replacements was three times as high in the poorest quintile of the population as the wealthiest quintile, the number of operations were no more common.⁷⁸⁷

3.2 Crucially—and this point cannot be emphasised enough—when the York team discussed their findings they observed that their study “did not include independent sector utilization”. About “a quarter of hip replacements in England are undertaken in the independent sector.” Relevantly, “[t]his non-NHS utilisation is concentrated among individuals and areas of high socio-economic status, particularly in the South East of England. Inequality in NHS utilisation therefore underestimates overall socio-economic inequality in utilisation”.⁷⁸⁸ Not only is there inequity in the provision of healthcare within the NHS, but also even more extreme inequity in the provision of healthcare across private and public services: that is, across healthcare taken as a whole. We shall return to this shortly.

GEOGRAPHICAL VARIATIONS

4.1 The NHS is patchy and there are signs that it is better in richer areas of the country. Recent statistics on meeting the 18-week target show that there are wide variations in performance across the country, with just 33 per cent of elective patients receiving treatment within 18 weeks in Hastings & Rother PCT against 82 per cent in Blackpool PCT.⁷⁸⁹ Where diagnostics—MRI and CT scans—are concerned, there are massive variations in waiting times. Whereas patients in Wales can expect to wait only 47 days for an MRI scan, those in the North East can expect to wait 100 days. And while there are a small number of hospitals, such as South Warwickshire General Hospitals NHS Trust, where you can get a routine MRI scan in less than ten days, there are equally a small number where you have to wait more than 170 days, such as the Royal United Hospital Bath NHS Trust.⁷⁹⁰ Similarly, patients are waiting just three days at University College London to receive a CT scan—but 141 days at Norfolk and Norwich University Hospital NHS Trust.⁷⁹¹ Where you live therefore determines how long you have to wait to access NHS services.⁷⁹²

4.2 Recent studies have also uncovered geographical variations in spending. Take expenditure on cancer treatment per cancer patient, where there is for example wide disparity between Nottingham City PCT, at £17,028 per cancer patient, and Oxfordshire PCT, at £5,182 per cancer patient.⁷⁹³ Expenditure per heart disease death is more marked, ranging from £166,151 in Wakefield PCT to £17,241 in Calderdale PCT.⁷⁹⁴

⁷⁸¹ Cookson, R., Dusheiko, M., and Hardman, G., *Socio-economic inequality in small area use of elective total hip replacement in the English NHS in 1991 and 2001*, CHE Discussion Paper 15, York: University of York, May 2006, p. 1.

⁷⁸² Dixon, A., et al., *Is the NHS equitable? A review of the evidence*, p. 2. See also: Morris, S., et al., *Inequity and inequality in the use of health care in England: an empirical investigation*, p. 28.

⁷⁸³ “The 1945 model, for all its great strengths, was not the answer to inequality”, Tony Blair, speech to the Fabian Society conference, June 2003.

⁷⁸⁴ Cookson, R., et al., *Socio-economic inequality in small area use of elective total hip replacement in the English NHS in 1991 and 2001*, p. 2.

⁷⁸⁵ Cookson, R., et al., *Socio-economic inequality in small area use of elective total hip replacement in the English NHS in 1991 and 2001*, p. 1.

⁷⁸⁶ Cookson, R., et al., *Socio-economic inequality in small area use of elective total hip replacement in the English NHS in 1991 and 2001*, p. 1.

⁷⁸⁷ Steel, H., Melzer, D., Gardener, E., and McWilliams, B., “Need for and receipt of hip and knee replacements—a national population survey”, *Rheumatology*, 2006; 45: 1437–1441.

⁷⁸⁸ Cookson, R., et al., *Socio-economic inequality in small area use of elective total hip replacement in the English NHS in 1991 and 2001*, p. 8.

⁷⁸⁹ DH, “18 weeks referral to treatment—commissioner based”, 2008. Available at: http://www.performance.doh.gov.uk/rtt/downloads/monthly/RTT_Admitted_Commissioner_Oct07.xls

⁷⁹⁰ Dr Foster, *How healthy is your hospital?*, London: Dr Foster, 2007, p. 15.

⁷⁹¹ Dr Foster, *How healthy is your hospital?*, p. 15.

⁷⁹² Bosanquet, N., de Zoete, H., Haldenby, A., *NHS reform: the empire strikes back*, London: Reform, 2007, p. 33. See also: Dr Foster, *How healthy is your hospital?*, p. 14.

⁷⁹³ http://www.hsj.co.uk/images/Conservatives%20cancer%20spend%20table%20261107_tcm11-297712.doc

⁷⁹⁴ Gainsbury, S., “Heart disease rates show a nation of inequalities”, HSJ, 17/01/08.

All of this means that there are variations in provision within specialties. Other surveys have found that a deaf person in one part of the country is likely to have more rapid access to a hearing aid than someone with the same condition in another part of the country.⁷⁹⁵ The same applies to stroke victims, too, and wide variations are also reported in the diagnosis and treatment of urological cancer, and in the treatment of multiple sclerosis.⁷⁹⁶ Dr Foster has found that in the emergency procedure, fractured neck of femur, if all trusts were up to the standard of the best performers then in the past three years more than 1,500 deaths could have been averted.⁷⁹⁷ And “there is still a four-fold variation in mortality rates between organisations” for coronary artery bypass graft (CABG) procedures.⁷⁹⁸ Variations in CABG treatment have consequences for equity. Julian Le Grand has shown that intervention rates of CABG or angiography are 30 per cent lower in the lowest socio-economic groups than in the highest.⁷⁹⁹

VULNERABLE GROUPS

5.1 A good deal of attention has also rightly been focussed on the fashionableness of health conditions and the quality of treatment provided, what have been called the Cinderella services. This is particularly an issue in a tax-funded system where HM Treasury controls the overall expenditure, so there is a government decision about how much to allocate and to what services. Despite the fact that the UK population is ageing, and there’s a higher proportion than ever before of older people in the community, the elderly depend on out-of-hospital care run by PCTs overloaded with responsibilities. It is, as the thinktank Reform notes, “the poor cousin of the acute sector”.⁸⁰⁰ The NHS is a long way from being able to offer an assurance of a high standard of care for admissions of frail elderly people, who then tend to stay for a long time. A recent study by the OECD has demonstrated that the elderly suffered substantial inequities, especially in hospitals or for specialist treatment and dental health. In terms of visiting GPs, the UK drops from 1st (for overall equity) to 9th (for equity for over 65-year-olds) in a list of EU countries.⁸⁰¹ If you are old and mentally ill things are even worse, as the Healthcare Commission found in 2006.⁸⁰²

5.2 Services vary widely across the country in mental health care.⁸⁰³ There are large disparities in spend by PCTs, from less than £75 per head per year to over £300 in 2004–05.⁸⁰⁴ An enquiry by the King’s Fund raised serious questions about variations in investment and gaps in information. The Audit Commission has found that this variation cannot be explained entirely by differences in levels of need, differences in volumes of activity, or differences in efficiency.⁸⁰⁵ In addition, the Healthcare Commission has reported serious problems with variations in care, including a wide gap between the North and the South.⁸⁰⁶ Further evidence of this has been gathered by Reform in a study of prescribing of atypical anti-psychotics in mental health. It showed that differing rates of prescribing in mental health are marked: fourteen of the bottom twenty performing PCTs were in the East Midlands and East Anglia, but only one in the South East; conversely, sixteen of the top performing PCTs were in the South East and London area and only four in the North or the Midlands.⁸⁰⁷ Not only is mental health less well served than other conditions, but the quality of the service varies widely, with the relatively affluent south doing better than less prosperous parts of the country. As the Healthcare Commission said in 2006 when it published its first national review of adult community health services, “some disadvantaged groups are more likely than others to fail to receive services”.⁸⁰⁸

ACCESS AND VOICE

6.1 It is now widely acknowledged that the system militates against lower socio-economic groups. Since there is evidence to show that the provision of primary care services in deprived areas is getting worse,⁸⁰⁹ despite concerted efforts to reverse the trend, there is much to suggest that “the inverse care law” operates, which is to say that areas which are poorer and therefore have greater health needs are less well served by the health service than wealthier and healthier areas.⁸¹⁰ The reality is more complex. Utilisation rates tell a different story. The majority of studies show that those of lower income and education status and ethnic minorities have higher use of primary care than those of higher income and education status. However, this

⁷⁹⁵ Bosanquet, N., et al., *The Empire Strike Back*, p. 39.

⁷⁹⁶ Dr Foster, *How healthy is your hospital?*, pp. 22–23.

⁷⁹⁷ Dr Foster, *How healthy is your hospital?*, p. 12.

⁷⁹⁸ Dr Foster, *How healthy is your hospital?*, p. 11.

⁷⁹⁹ Le Grand, J., “The Blair Legacy? Choice and Competition in Public Services”, lecture to the LSE, February 2006.

⁸⁰⁰ Bosanquet, N., et al., *The Empire Strike Back*, p. 37.

⁸⁰¹ Cited in DH, *Better Care for Patients*, London: DH, unpublished 2006, p. 16.

⁸⁰² Healthcare Commission, *Living well in later life: A review of progress against the NSF for older people*, London: Healthcare Commission, 2006. Cited in Bosanquet, N., et al., *The Empire Strike Back*, pp. 37–38.

⁸⁰³ “Revealed the postcode lottery for mental health patients”, *Independent on Sunday*, 29/10/06.

⁸⁰⁴ Audit Commission, *Managing finances in mental health*, London: Audit Commission, 2006, pp. 4, 19.

⁸⁰⁵ Audit Commission, *Managing finances in mental health*, pp. 4, 19.

⁸⁰⁶ Cited in Bosanquet, N., et al., *Mental health services in the NHS: using reform incentives*, London: Reform, 2006, p. 11.

⁸⁰⁷ Bosanquet, N., et al., *Mental health services in the NHS*, p. 13.

⁸⁰⁸ Healthcare Commission, *Health watchdog highlights gaps in mental health care*, London: Healthcare Commission, press release 29 September 2006, cited in Bosanquet, N., et al., *Mental health services in the NHS*, p. 12.

⁸⁰⁹ DH, *Tackling Health Inequalities: Status Report on the Programme for Action—2006 Update of Headline Indicators*, London: DH, December 2006.

⁸¹⁰ Tudor Hart, J., “The inverse care law”, *The Lancet*, 1971, 405–12.

is reversed in access to secondary care,⁸¹¹ where “the rich are significantly more likely to see a specialist than the poor”.⁸¹² This indicates that under utilisation of secondary care by lower socio-economic groups doesn’t appear to be caused by a reluctance to seek an initial consultation with a GP, despite barriers to treatment.⁸¹³

6.2 Generally this is taken to imply that, having made it to their GP, the poor “experience another set of difficulties, which manifest themselves in lower rates of referral to secondary and tertiary care, lower rates of intervention relative to need, and lower and irregular attendance at chronic disease management clinics.”⁸¹⁴ Many barriers operate differentially—that is, are more significant for disadvantaged groups. Transport is one. Another is voice. Voice is simply a catchall for communication difficulties, language, literacy, assertiveness, articulation, self-confidence, ability to deal with professionals, and so on.⁸¹⁵ The idea is that the middle classes get more out of the health service because they are better at expressing their needs.⁸¹⁶ The idea of voice is suggestive. Information is not transmitted freely in the NHS—as would be expected in a properly functioning market—and standards vary wildly. Unofficial forces prevail, like learning, manners, and above all knowledge of how the system works, gained through establishing a complicit relationship with the best sources of information of all: the staff. Certainly, higher socio-economic groups are more likely to have family or friends who work in the health services, and even if these contacts are not directly used to gain access to services they act as an important source of advice on how to work the system.⁸¹⁷

6.3 Also relevant within the voice catchall is how pushy people are: at least one study—of hip replacement utilisation—has found “evidence of the effectiveness of the “sharp elbows” of the middle class in the welfare state”.⁸¹⁸ The middle classes are just better at insisting on their rights and standing up to administrative gatekeepers than their less confident, less articulate fellow sufferers. They demand and get priority treatment. So ironically, an arrangement designed to remove the role of money in the system, far from abolishing inequality, reinforces it. The ability to get the most out of the NHS becomes a matter of survival of the fittest—or richest and most educated. The system offers different services to different people in different parts of the country, and quality and access vary widely. A completely new set of strategies or—as argued in *Quite Like Heaven?*—a reconfigured system will be required in order to improve patient pathways and join up care so that GPs effectively help patients navigate the care cycle. Better information and reporting of outcomes, made mandatory and made available to the public will also be axiomatic in a consumer-oriented model that harnesses market forces.

A TWO TIER SYSTEM

7.1 As if this wasn’t bad enough, because public and private healthcare systems exist in parallel, patients have differential access to services according to what they are willing or able to pay.⁸¹⁹ There has always been a two tier system in the UK, yet this runs counter to the ideal of social solidarity. Since the early 1990s, about 11.5 per cent of the UK population has had some form of private medical insurance, either personal or corporate cover.⁸²⁰ There are some indications that, as of last year, the number has started to creep up. At any rate, the figures are particularly dramatic for those who know best about the quality of the NHS’s service: the doctors themselves. The results of a 2007 survey of 1,700 GPs carried out by *Hospital Doctor* magazine found that 28 per cent of GPs have private medical insurance, and 33 per cent would prefer private treatment if they fell ill,⁸²¹ and a survey commissioned by BUPA found that for hospital consultants the figure rises to 55 per cent.⁸²²

7.2 What’s more, others are bypassing the blockages for specific treatments with out-of-pocket payments. Anecdotal evidence suggests that this is happening with increasing regularity. There has been no official attempt to map the scale of this trend, but there is a growing body of material which shows that patients are beginning to develop sophisticated approaches to purchasing upgrades to their basic NHS care. As Allyson Pollock has written: “a “half way house” is beginning to emerge where NHS patients are invited to supplement their NHS care by paying a “top up” fee. Recent examples include maternity care, where

⁸¹¹ See for instance: Morris, S., et al., *Inequity and inequality in the use of health care in England: an empirical investigation*, p. 3.

⁸¹² Van Doorslaer, et al., *Income-Related Inequality in the Use of Medical Care in 21 OECD Countries*, p. 6. Emphasis in original.

⁸¹³ Morris, S., et al., *Inequity and inequality in the use of health care in England: an empirical investigation*, p. 29.

⁸¹⁴ Dixon, A., et al., *Is the NHS equitable? A review of the evidence*, p. 29. My emphasis.

⁸¹⁵ Hirschman, A., *Exit, Voice and Loyalty*, Cambridge, Mass.: Cambridge University Press, 1970.

⁸¹⁶ Richards, H., Reid, M., Watt, G., “Socioeconomic variations in responses to chest pain: qualitative study”, *BMJ*, 2002; 324 (7349): 1308. See also: Gardner, K., Chapple, A., “Barriers to referral in patients with angina: qualitative study”, *BMJ*, 1999; 319 (9263): 1168–71.

⁸¹⁷ Richards, H., Reid, M., Watt, G., “Socioeconomic variations in responses to chest pain: qualitative study”, *BMJ*, 2002; 324 (7349): 1308.

⁸¹⁸ Proper, C., Eachus, J., Chanc, P., Pearson, N., and Davey Smith, G., “Access to health care resources in the UK: the case of care for arthritis”, *Health Economics*, 2005; 14: 391–406. Cited in Cookson, et al., *Socio-economic inequality in small area use of elective total hip replacement in the English NHS in 1991 and 2001*, p. 2.

⁸¹⁹ Foubister, T., Thomson, S., Mossialos, E., McGuire, A., *Private Medical Insurance in the United Kingdom*, London: European Observatory on Health Systems and Policies, 2006, pp. 12–14.

⁸²⁰ Foubister, T., et al., *Private Medical Insurance in the United Kingdom*, p. xv.

⁸²¹ Sergeant, H., “National Hypocrisy Service”, *Daily Mail*, 09/02/07.

⁸²² Templeton, S-K., “Senior doctors avoid being treated on NHS”, *The Sunday Times*, 08/07/07.

patients can opt to buy a “superior” package of care, covering services which were once free to all women in labour, and MRI scans and dermatology, where patients bypass the waiting list by paying for them privately.”⁸²³

7.3 Nor should this surprise us. With PCTs struggling to balance their books, the range of treatments available on the NHS is being cut, creating hidden waits and postcode lotteries; but in our modern consumer age, people don’t want to wait or suffer delays and they don’t want to be told they can’t have a life-saving or life-enhancing treatment by politicians who they don’t trust at the best of times. It’s also possible that all the rhetoric of choice in the NHS has stretched people’s expectations even further, and as some private treatments become cheaper and more accessible in the marketplace, attitudes are becoming more amenable to using them. It is getting harder to credibly argue that healthcare in this country is comprehensive and available to all irrespective of the ability to pay. As a recent paper for Doctors for Reform has argued: “We run the risk of achieving the worst of all worlds: inequitable NHS provision combined with inequitable provision outside the service. In both worlds the least well-off are disadvantaged.”⁸²⁴

7.4 Recommendations for changes to improve the quality, performance and outcomes, along with consumer responsiveness, while also offering the prospect of reducing inequities, would have to be swingeing and systemic. Some tentative suggestions have been made in my recent book, *Quite Like Heaven?* It is beyond the scope of this paper to examine these possible options, but I would be more than happy to extrapolate orally or in a further written submission.

Nick Seddon

Author, *Quite Like Heaven? Options for the NHS in a Consumer Age*, Honorary Research Fellow, Civitas
February 2008

⁸²³ Talbot-Smith, A., and Pollock, A. M., *The New NHS*, p. 180.

⁸²⁴ Charleson, P., Lees, C., and Sikora, K., *Free at the point of delivery—reality or political mirage? Case studies of top-up payments in UK healthcare*, London: Doctors for Reform, 2007, p. 5.

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